

AMERICA  
 112 3432

Private      \*Member: \_\_\_\_\_  
 Respite Care  
 Veteran (VA)      \*Worker: \_\_\_\_\_

Home Services (Caregiver)       Home Health Services (RN, LPN, CNA)

**\*Supervisor Name:** \_\_\_\_\_

mm/yy: ___/___	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Day of the Date:							
Time In:							
Time Out:							
Daily Total:							
<b>PERSONAL CARE</b>							
Bath							
Oral Hygiene							
Hair Care							
Assist Dressing							
Shave							
Skin Care							
Other:							
<b>NUTRITION</b>							
Prepare Breakfast							
Prepare Lunch							
Prepare Dinner							
Prepare Snack							
Assist Eating							
Grocery Shopping							
Other:							
<b>ACTIVITIES</b>							
Ambulation							
Transfer: Bed/Chair							
Turn/Reposition							
ROM Exercises							
Other:							
<b>RECORD</b>							
Temperature							
Pulse							
Respiration							
Blood Pressure							
Assist with Meds							
Food Intake							
Fluid Intake							
Other:							
<b>HOMEMAKING</b>							
Linen Change							
Laundry							
Wash Dishes							
Light Housework							
Other:							
<b>ELIMINATION</b>							
Bowel Movement							
Urination							
Catheter Care							
Ostomy Care							

**\*Daily Record**

**\*Mon. Notes:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*Worker Signature:** \_\_\_\_\_

**\*Patient Signature:** \_\_\_\_\_

**\*Tue. Notes:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*Worker Signature:** \_\_\_\_\_

**\*Patient Signature:** \_\_\_\_\_

**\*Wed. Notes:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*Worker Signature:** \_\_\_\_\_

**\*Patient Signature:** \_\_\_\_\_

**\*Thu. Notes:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*Worker Signature:** \_\_\_\_\_

**\*Patient Signature:** \_\_\_\_\_

**\*Fri. Notes:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*Worker Signature:** \_\_\_\_\_

**\*Patient Signature:** \_\_\_\_\_

**\*Sat. Notes:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*Worker Signature:** \_\_\_\_\_

**\*Patient Signature:** \_\_\_\_\_

**\*Sun. Notes:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*Worker Signature:** \_\_\_\_\_

**\*Patient Signature:** \_\_\_\_\_

WEEKLY TOTAL: \_\_\_\_\_

**CARE COORDINATION/CONFERENCE & SUPERVISORY VISIT:**

FOLLOWING PLAN OF CARE:     YES     NO

CLIENT/FAMILY SATISFIED WITH CARE     YES     NO  
 APPROPRIATE & NECESSARY CARE PROVIDED:     YES     NO

\*SIGNATURE OF SUPERVISOR \_\_\_\_\_

DATE \_\_\_\_\_

FIRST NAME AND LAST NAME

DATE -----

9:00 AM

B/P

TEMPERATURE

BREAKFAST. ....

LUNCH

MEDICINE

1:00 PM

2:00

5:00 PM

DINNER

MEDICINE