

MediCare HHA Documentation Record

Week Begin Date _____	Date	MON ___	TUE ___	WED ___	THUR ___	FRI ___	SAT ___	SUN ___
TIME IN:								
TIME OUT:								
TOTAL HOURS:								
Personal Care TOTAL TIME								
Homemaking TOTAL TIME								
Patient Identifiers-See numbers below								
VITALS -WEIGHT RESULTS								
HR, RR, BP, TEMP ORAL/AXILLARY/RECTAL								
BATHING- BED-TUB (T)/SHOWER(S)								
SPONGE BATH IN CHAIR OR BED								
BED BATH-PART (P)/COMPLETE(C)								
HYGIENE/GROOMING-ASSIST BATH-CHAIR								
HAIR-BRUSH/WASH/OTHER								
SKIN-LOTION (L)/POWDER(P)								
DRESSING								
CHECK PRESSURE AREAS								
SHAVE/GROOM/DEODORANT								
NAILS- CLEAN/FILE/REPORT								
ORAL- BRUSH/SWAB/DENTURES								
TOLIETING HYGIENE/PERI CARE								
FOOT-CLEAN(C),LOTION(L),ELEVATE(E)								
PROCEDURES- OSTOMY EMPTY								
CATHETER EMPTY								
RECORD I/O								
<u>INSPECT PRESSURE POINTS</u>								
MEDICATION REMINDER								
REINFORCE WOUND DRESSING								
MAINTAIN STANDARD PRECAUTIONS								
<u>OBSERVE FOR FALL RISK</u>								
ACTIVITY-CANE (C)/WC/WALKER (W) BSC								
ROM- ACTIVE/PASSIVE PER PT/TO								
<u>REPOSITIONING- TURN Q 2 HOURS</u>								
EXERCISE PER PT/OT/SLP PLAN								
NUTRITION-DIET ORDER:								
ASSIST WITH FEEDING								
MEAL PREP/REMIND OF PO SUPPLEMENT								
LIMIT/ENCOURAGE FLUIDS								
GROCERY SHOPPING/ERRANDS								
HOUSEKEEPING- LAUNDRY								
MAKE BED(MB), CHANGE LINEN(CL)								
MOP (M), SWEEP(S),DUST(D)								
(L) LIVING/ (B)BATHROOM/ (K)KITCHEN								
CLEAN EQUIPMENT								
TRASH REMOVAL								
ASSIST WITH PAIN MGT								

P E R S O N A L C A R E

H O M E M A K I N G

Date	Client Name	Client Signature	Date	Employee Name	Employee Signature

Patient Identifiers: 1. KNOWN TO ME 2. STATES NAME 3. CG STATES Pt NAME 4. ADDRESS CORRECT