MED1CARE **Home Health Aide Documentation** MED1CARE

	Week begin date_________	Mon___	Tue___	Wed___	Thu___	Fri___	Sat___	Sun___
	TIME IN:							
PERSONAL CARE	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)							
	HYGEINE/GROOMING-ASSIST BATH CHAIR							
	HAIR-BRUSH/WASH/OTHER							
	SKIN-LOTION (L)/POWDER (P)							
	DRESSING							
	CHECK PRESSURE POINTS							
	SHAVE/GROOM/DEODORANT							
	NAILS-CLEAN/FILE/REPORT							
	ORAL-BRUSH/SWAB/DENTURES							
	TOILETING HYGEINE/PERI CARE							
	FOOT CLEAN(C), LOTION(L), ELEVATE(E)							
	PROCEDURES- OSTOMY EMPTY							
	CATHETER EMPTY							
	RECORD I/O							
	INSPECT PRESSURE POINTS							
	MEDICATION REMINDER							
	REINFORCE WOUND DRESSING							
	MAINTAIN STANDARD PRECAUTIONS							
	OBSERVE FOR FALL RISK							
HOUSEKEEPING	ACTIVITY-CANE(C)/WC/WALKER (W) BSC							
	ROM-ACTIVATE/PASSIVE PER PT/OT							
	REPOSITIONING-TURN Q 2 HOURS							
	EXERCISE PER PT/OT/SLP PLAN							
	NUTRITION-DIET ORDER:							
	ASST 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 MGMT							

Month	Day	Year	Client Name	Client Signature	Month	Day	Year	Employee Name	Employee Signature

Patient Identifiers: 1. Known to me 2. States name 3. CG states pt. name 4. Address correct