

HOME CARE ASSISTANT SERVICE NOTE

BATH N/A Declined

- Bed bath
- Sponge bath
- Shower
- Tub bath

ORAL CARE N/A Declined

- Brush teeth
- Denture care
- Swabs

HAIR CARE N/A Declined

- Shampoo
- Comb
- Other _____

OTHER CARE

- Electric Mental status _____
- Safety Hearing _____
- Face Glasses
- Underarms Contact lenses
- Legs Smoking
- Shave

BEDMAKING N/A Declined

- Occupied
- Unoccupied
- Linen change

FOOT/NAIL CARE N/A Declined

- Clean nails
- Soak feet
- Paint nails

ASSIST WITH DRESSING N/A Declined

- Total assist
- Minimal assist/reminders

DIET _____

- Meal preparation N/A Declined
- Feed
- Assist
- Nothing by mouth

TRANSFER/ASSIST N/A Declined

- Support
- Assist
- Confined to bed
- Reposition _____
- Fall risk

EQUIPMENT/SUPPLIES N/A Declined

- Gait belt Incontinence supplies
- Walker Wound supplies
- Cane Nutritional supplements
- Wheelchair Gloves
- Bedside commode Other _____
- Urinal
- Hospital bed
- Hoyer lift

SKIN CARE N/A Declined

- Lotion
- Powder
- Deodorant
- Other _____

CARE OF ENVIRONMENT N/A Declined

- Clean client's bedroom
- Clean client's bathroom
- Do client's laundry
- Keep client's area neat/clean
- Other _____

MEDICATIONS N/A Declined

- Remind client to take medications
- Family assists with medications

ELIMINATION N/A Declined

- Check voiding
- Check bowel movement
- Change diaper/pad
- Incontinent of urine
- Incontinent of bowel
- Foley catheter
- Foley cath care with soap/water
- Suprapubic catheter
- External catheter
- Other _____

SAFETY MEASURES N/A Declined

- Siderails
- Pathways clear
- Other _____

TRANSPORT Yes No

- Client car
- Employee car
- Accompany client when family drives

Comments

Employee Signature/Title

Date

Time In

Time Out

Client/Caretaker Signature

Date

Billable Mileage

CLIENT INFORMATION

Last Name

First Name

ID No.

*N/A = Not Assigned

