GOOD CARE AGENCY, INC.
2671 CONEY ISLAND AVENUE
BROOKLYN, NY 11235
TEL. 718-635-3535
FAX: 718-513-4427

COORDINATOR NAME: ____________________

HHA/PCA VISIT RECORD

PATIENT'S NAME: ______________________________ PHONE # ____________

PATIENT'S ADDRESS: ______________________________

EMPLOYEE NAME: ______________________________ EMPLOYEE NUMBER: ____________

Check each block for care provided that day as directed from Aide Care Plan. Mark the block with "R" if the Patient refused the care. Fill in the date under each day serviced

ASSIGNMENT/TASKS	SA	SU	M	T	W	TH	F
DATE *Year:*	/	/	/	/	/	/	/
Bath: [] Complete [] Partial [] Bed(18)							
[] Tub(15) [] Shower(16) [] Sponge(17)							
[] Skin Care(23) [] Foot Care(20)							
Nail Care: [] Clean/File(24)							
Shave: [] Electric [] Safety Razor							
Hair: [] Shampoo(21) [] Brush/Comb							
Oral Care:(19) [] Teeth [] Dentures							
Dress:(27) [] Self [] Assist [] Total							
Transfers: [] 1-person(43) [] 2-person(45)							
[] Board(46) [] Mechanical Lift(47)							
Walking: [] Assist(40) [] Supervise(41)							
Device:(45) [] Cane [] Walker [] Crutches							
Reposition:(48) [] PRN [] Bed [] W/C							
Toileting:(25) [] Bathroom [] Commode							
[] Bedpan [] Urinal [] Diaper							
[] Catheter Care(61) [] Empty Drainage Bag							
Incontinent Care(26) [] Bladder [] Bowel							
Diet Instruction:							
[] Reinforce Diet(55) [] Feed Patient(56) [] Assist with feeding(57)							
Prepare Meals:(58) [] Breakfast [] Lunch [] Dinner [] Snack							
[] Fluid Restrictions [] Encourage Fluids							
[] Remind Patient To Take Medications(60)							
Tidy:(80) [] Living Areas [] Bathroom [] Kitchen							
[] Bedroom [] Change Linen [] Make Bed							
Patient's Laundry: [] Wash/Dry/Fold(82)							
[] Trash Removal							
[] Shopping(81)							
[] Social Activities							
Accompany patient to: [] MD(83) [] Other(84)							

Supervisor Notified: Name, Date

Day	Date	Time In	Time Out	Total Time	Patient/Caregiver Signature	Employee Signature, Title
Sat	/ /					
Sun	/ /					
Mon	/ /					
Tues	/ /					
Wed	/ /					
Thurs	/ /					
Fri	/ /					

By my signature I certify that I have been oriented to this patient's plan of care. I have reviewed the Aide Care Plan for any changes or updates and that his client received the services checked above. The information documented here is true and correct.

J101 Rev. 4/2007