

HHA/PCA VISIT RECORD

COORDINATOR NAME: _____

PATIENT NAME: _____

PATIENTS ADDRESS: _____ PHONE: _____

EMPLOYEE NAME: _____ PHONE: _____

Check each block for care provided that day as directed from Aide Care Plane. Mark the block with "R" if the Patient refuses the care.

DATE: ___/___/202__		SUN	MON	TUE	WED	THU	FRI	SAT
ASSIGNEMENT/TASK								
Bath:	<input type="checkbox"/> Complete	<input type="checkbox"/> Partial	<input type="checkbox"/> Bed					
	<input type="checkbox"/> Tub	<input type="checkbox"/> Shower	<input type="checkbox"/> Sponge					
	<input type="checkbox"/> Skin Care	<input type="checkbox"/> Foot care						
Nail care:	<input type="checkbox"/> Clean/File							
Shave:	<input type="checkbox"/> Electric	<input type="checkbox"/> Safety razor						
Hair:	<input type="checkbox"/> Shampoo	<input type="checkbox"/> Brush/Comb						
Oral care:	<input type="checkbox"/> Teeth	<input type="checkbox"/> Dentures						
Dress:	<input type="checkbox"/> Self	<input type="checkbox"/> Assist	<input type="checkbox"/> Total					
Transfers:	<input type="checkbox"/> 1-person	<input type="checkbox"/> 2-person						
	<input type="checkbox"/> Board	<input type="checkbox"/> Mechanical lift						
Walking:	<input type="checkbox"/> Assist	<input type="checkbox"/> Supervise						
Device:	<input type="checkbox"/> Cane	<input type="checkbox"/> Walker	<input type="checkbox"/> Crutches					
Reposition:	<input type="checkbox"/> PRN	<input type="checkbox"/> Bed	<input type="checkbox"/> W/C					
Toileting:	<input type="checkbox"/> Bathroom	<input type="checkbox"/> Commode	<input type="checkbox"/> Bedpan					
	<input type="checkbox"/> Urinal	<input type="checkbox"/> Diaper						
	<input type="checkbox"/> Catheter care	<input type="checkbox"/> Empty drainage bag						
	<input type="checkbox"/> Incontinent care	<input type="checkbox"/> Bladder	<input type="checkbox"/> Bowel					
Diet Instruction:	<input type="checkbox"/> Reinforce diet	<input type="checkbox"/> Feed patient						
	<input type="checkbox"/> Assist with feeding							
Prepare meals:	<input type="checkbox"/> Breakfast	<input type="checkbox"/> Dinner	<input type="checkbox"/> Snack					
	<input type="checkbox"/> Lunch							
	<input type="checkbox"/> Fluid restrictions	<input type="checkbox"/> Encourage fluids						
	<input type="checkbox"/> Remind patient to take medications							
Tidy:	<input type="checkbox"/> Living areas	<input type="checkbox"/> Bathroom	<input type="checkbox"/> Kitchen					
	<input type="checkbox"/> Bedroom	<input type="checkbox"/> Change linen	<input type="checkbox"/> Make bed					
Patient's laundry:	<input type="checkbox"/> Wash/Dry/Fold							
<input type="checkbox"/> Thrash removal								
<input type="checkbox"/> Shopping								
<input type="checkbox"/> Social activities								
<input type="checkbox"/> Accompany patient to:	<input type="checkbox"/> MD	<input type="checkbox"/> Other						
Day	Date	Start time	Finish time	Total time	Patient's Signature	Employee's Signature		
SUN								
MON								
TUES								
WED								
THU								
FRI								
SAT								

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 this client received the services checked above. The information documented here is true and correct.