Home and Health Care Management **HOME HEALTH AIDE RECORD**

VITAL SIGNS

Temperature:	Pulse:	Respirations:	BP: /	Weight:

Mental status: (Check all that apply) ☐ Alert ☐ Oriented ☐ Disoriented ☐ Cooperative ☐ Resistive ☐ Demanding ☐ Lethargic ☐ Cheerful ☐ Anxious ☐ Depressed ☐ Confused

PERSONAL CARE SERVICES

Bed Bath: ☐ Complete ☐ Partial ☐ Shower ☐ Tub ☐ Shampoo ☐ Pericare ☐ Foley cath care ☐ Other:	☐ Oral Hygiene ☐ Dentures Shaved: ☐ Electric ☐ Razor ☐ Comb & Brush Hair ☐ Clean & File Nails ☐ Dressing Activity ☐ Applied elastic bandage/ TED stockings	Skin: ☐ Clean and dry ☐ Reddened or open areas: _____ ☐ Lotion Applied ☐ Powder applied ☐ Other:	☐ Assisted with Toilet ☐ BSC ☐ Urinal ☐ Bedpan Emptied: ☐ Cath ☐ Bag Output:_____ Urine Characteristics: _____ Date last BM:

Comments:

NUTRITION

☐ Prepared Client's meal ☐ Served Meal ☐ Assisted in Feeding ☐ Fed Client Fluids: ☐ Encouraged ☐ Limited

Comments:

ACTIVITIES AND LIMITATIONS

Bed Rest: ☐ Complete ☐ BathRoom Privileges ☐ Positioned/turned q _____ hrs ☐ Transfer bed/chair ☐ Up as Tolerated ☐ Side Rails Up	☐ Assisted with Ambulation uses ☐ Walker ☐ Crutches ☐ Cane ☐ Wheelchair (Assure brakes locked) Other:_____ ☐ Encouraged Ambulation	Range of Motion performed by staff: ☐ Active ☐ Passive ☐ Home Exer Prog Assisted with transfers: ☐ Min ☐ Mod ☐ Max Assist ☐ Slide board ☐ Transfer belt ☐ Mechanical lift ☐ Grab bars

Comments:

PATIENT-ORIENTED HOMEMAKING

☐ Made Bed ☐ Changed linen ☐ Vacuumed ☐ Dusted ☐ Straightened ☐ Did patient's personal laundry	☐ Cleaned Bathroom ☐ Cleaned Kitchen ☐ Washed patient's dishes	☐ Did marketing/errands ☐ Other:

Comments:

MEDICATIONS	RESPITE/COMPANIONSHIP
☐ Reminded client to take medications ☐ Observed self-administration of medication Comments:	☐ Provided Respite for Caregiver ☐ Provided companionship services for Client Comments:
☐ Transported to: via:	☐ Client's Car ☐ Aide's Car ☐ Public Transportation ☐ Non-emergency medical transportation

PROBLEMS OBSERVED OR CLIENT CHANGES:

NEW SAFETY CONCERNS IDENTIFIED:

☐ **Above Problem discussed/communicated with**: at: AM PM

I certify that I have reviewed the current Plan of Care dated From:_____Thru:_____prior to performing care

I certify that the Date, Time and Services rendered as indicated on this record are correct, accurate and have been verified by the client.

Date:	Time In:	Time Out:

Staff Signature: Title:

I certify that the Date, Time and Services rendered as indicated on this record are accurate as reflected by the employee.

_____

Patient/Representative Signature

Patient Name:_____ HC #: _____