

NUTRITION

Prepared Client's meal: Diet _____ Served Meal

Comments:

HOUSEHOLD SERVICES

<input type="checkbox"/> Made Bed	<input type="checkbox"/> Cleaned Living/Family Room	<input type="checkbox"/> Cleaned Bathroom
<input type="checkbox"/> Changed Linens	<input type="checkbox"/> Cleaned Kitchen	<input type="checkbox"/> Cleaned Bedroom
<input type="checkbox"/> Swept	<input type="checkbox"/> Washed Dishes	<input type="checkbox"/> Other cleaning services:
<input type="checkbox"/> Vacuumed	<input type="checkbox"/> Did Laundry	
<input type="checkbox"/> Mopped		

Comments:

MEDICATIONS

Reminded re: self-administration of medication Observed self-administration of medication

Comments:

COMPANIONSHIP SERVICES

Provided Companionship Services to Client

Comments:

TRANSPORTATION

<input type="checkbox"/> Transported to:	Via:	<input type="checkbox"/> Client's Car	<input type="checkbox"/> Homemaker's Car
<input type="checkbox"/> Did marketing/ran errands for client:	<input type="checkbox"/> Public Transportation	<input type="checkbox"/> Non-emergency medical transport	

PROBLEMS OBSERVED OR CLIENT CHANGES:

NEW SAFETY CONCERNS IDENTIFIED:

Above Discussed/Communicated with: _____ at: _____ AM PM

<p>I certify that I have reviewed the current Plan of Care dated From: _____ To: _____ prior to performing services</p>		
<p><i>I certify that the Date, Time and Services rendered as indicated on this record are correct, accurate and have been verified by the client.</i></p>		<p><i>I certify that the Date, Time and Services rendered as indicated on this record are accurate as reflected by the employee.</i></p>
Date:	Time In:	Time Out:
<p>Staff Signature: _____</p>		<p>Patient/Representative Signature _____</p>
<p>Title: _____</p>		

Patient Name: _____ HC #: _____