**Home and Health Care Management** **PERSONAL CARE ATTENDANT 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<br>☐ Shower ☐ Tub<br>☐ Shampoo ☐ Pericare<br>☐ Foley cath care<br>☐ Other: | ☐ Oral Hygiene ☐ Dentures<br>Shaved: ☐ Electric ☐ Razor<br>☐ Comb & Brush Hair<br>☐ Clean & File Nails<br>☐ Dressing Activity<br>☐ Applied elastic bandage/ TED stockings | Skin: ☐ Clean and dry<br>☐ Reddened or open areas:<br>_____<br>☐ Lotion Applied<br>☐ Powder applied<br>☐ Other: | ☐ Assisted with Toilet<br>☐ BSC ☐ Urinal ☐ Bedpan<br>Emptied: ☐ Cath ☐ Bag<br>Output:_____<br>Urine Characteristics:<br>_____<br>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:<br>☐ Complete ☐ BathRoom Privileges<br>☐ Positioned/turned q _____ hrs<br>☐ Transfer bed/chair<br>☐ Up as Tolerated<br>☐ Side Rails Up | ☐ Assisted with Ambulation uses<br>☐ Walker ☐ Crutches<br>☐ Cane ☐ Wheelchair<br>(Assure brakes locked)<br>Other:_____<br>☐ Encouraged Ambulation | Range of Motion performed by staff:<br>☐ Active ☐ Passive ☐ Home Exer Prog<br>Assisted with transfers:<br>☐ Min ☐ Mod ☐ Max Assist<br>☐ Slide board ☐ Transfer belt<br>☐ Mechanical lift ☐ Grab bars |

Comments:

## PATIENT-ORIENTED HOMEMAKING

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

Comments:

| MEDICATIONS | RESPITE/COMPANIONSHIP |
|---|---|
| ☐ Reminded client to take medications<br>☐ Observed self-administration of medication<br>Comments: | ☐ Provided Respite for Caregiver<br>☐ Provided companionship services for Client<br>Comments: |
| ☐ Transported to:<br>via: | ☐ Client's Car ☐ Aide's Car ☐ Public Transportation<br>☐ 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:_____To:_____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.*** | | | ***I certify that the Date, Time and Services rendered as indicated on this record are accurate as reflected by the employee.*** |
|---|---|---|---|
| Date: | Time In: | Time Out: | _____<br>**Patient/Representative Signature** |
| **Staff Signature**: | | Title: | |

Patient Name:_____ HC #: _____