Please fax this form to (480) 445-9930
no later than Monday at 10:00am.

NOTE: Falsification of time sheets will result in termination. Print all information clearly – Illegible and incomplete information or late submission of time sheets WILL delay payment.

Week of

_______/_______/2016

through

_______/_______/2016

____
Home Health Aide Name (Last, First, MI)

____
Client Name (Last, First, MI)

CAREGIVER VISIT NOTE

	SUN	MON	TUES	WED	THUR	FRI	SAT
Date:							
Time in:							
Time out:							
TOTAL HOURS:							
Grand Total Hours Worked: (add up all total hours)							

HYGIENE ACTIVITIES (circle one)	SUN	MON	TUES	WEDS	THURS	FRI	SAT
Tub / Sponge / Shower / Bed Bath							
PERSONAL CARE (circle one)							
Assist w/dressing / Skincare							
Hair Care - Brush / Shampoo / Other							
Groom / Deodorant							
Nail Hygiene: Clean / File (Do NOT Cut!)							
Oral Care - Brush / Swab / Denture care							
Toilet / Bedside Commode / Incontinence Brief							
PROCEDURES (circle one)							
Catheter Care/ Empty Drainage Bag							
Ostomy Bag/ Empty Drainage Bag							
ACTIVITY (circle one)							
Ambulation Assist WC / Walker / Cane							
Transfer Assist							
ROM Passive / Active							
Positioning: Encourage / Assist to turn q 2 hrs							
Exercise – Per PT / OT / ST Care Plan							
NUTRITION (circle one)							
Meal Preparation / Planning / Serve							
Assist with Feeding							
Limit / Encourage Fluids							
DAILY LIVING (circle one)							
Errands							
Wash Clothes / Laundry/ Put away / Iron							
Light Housekeeping: Bedroom / Bathroom / Kitchen / Living Room Change Bed / Make Bed							
Dust / Vacuum							
Medication Reminders							

Aide Signature/Title:	**Date:**
Patient Signature*:	**Date:**

*Please do not sign until the end of the week and the *Caregiver Visit Note* is fully complete.

Questions? Call (480)444-7788