

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

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

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Week of

\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/2016

through

\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/2016

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|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** |  |  |  |  |  |  |  |  |

AHH Caregiver Visit Note, Revised 12/2015.