

**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.