____
Client Name

____
Employee Name

Check All Task Provided!

Office Use Only	________________
Client Number	________________
Supervisor Initials	________________

	DATE	DATE	DATE	DATE	DATE	DATE	DATE
Visit Date							
Time In							
Time Out							
	FRI	SAT	SUN	MON	TUE	WED	THR
Body Mech /Mobility							
Transfers							
Ambulation							
Cane / Walker							
Prescribed ROM							
Turning & Positioning							
Bath							
Tub							
Shower							
Bed							
Chair							
Oral Hygiene							
Brush Teeth							
Clean Dentures							
Mouth Wash							
Oral Swabs							
Hair Care							
Comb / Brush							
Shampoo							
Skin & Nail Care							
Warm / Dry							
Diaphoretic							
Redness / Bruising							
Apply Lotion							
Nail Cleaning /Filling							

	FRI	SAT	SUN	MON	TUE	WED	THR
Personal Care							
Dressing							
Shaving							
Pet Care							
Elimination							
Bed Pan							
Bedside Commode							
Colostomy Care							
Catheter Care							
Assist on Toilet							
Nutrition							
Prepare Meals							
Serve Meals							
Assist Feeding							
Offer Fluids							
Homemaking / Non-personal Care							
Shopping							
Errands							
Transporting							
Dust							
Vacuum							
Straiten							
Wash Dishes							
Clean Kitchen							
Clean Bathroom							
Make Bed							
Change Bed							
Laundry							
Safety							
Reminder							

____
Employee Signature Date

____
Title

____
Patient Name (PLEASE PRINT) Date

____
Patient Signature