



Personal Care Aide/Homemaker/Companion

Visit Note

A selection **MUST** be made for each authorized service.

✓ = Performed R = Refused

Incomplete timecards will not be accepted.

Week Of: ___/___/___ to ___/___/___

	SUN	MON	TUES	WED	THURS	FRI	SAT	COMMENTS
Consumer Name: _____ Visit Date _____								
Employee Name: _____ Time In _____								
Time Out _____								
Consumer-Specific Service Plan Reviewed Daily								
Safety: <input type="checkbox"/> Side Rails <input type="checkbox"/> Supervise Activity <input type="checkbox"/> Universal Precautions								
Bathing Assistance: <input type="checkbox"/> Tub <input type="checkbox"/> Shower <input type="checkbox"/> Bed <input type="checkbox"/> Bench/Chair								
Oral Care: <input type="checkbox"/> Denture Care <input type="checkbox"/> Brush Teeth <input type="checkbox"/> Mouthwash								
Hair Care: <input type="checkbox"/> Shampoo <input type="checkbox"/> Comb/Brush <input type="checkbox"/> Set								
Skin Care: <input type="checkbox"/> Skin Care/Lotion <input type="checkbox"/> Turn/Position <input type="checkbox"/> Wound Care								
Feet: <input type="checkbox"/> Foot Care <input type="checkbox"/> Lotion <input type="checkbox"/> Elevate Feet								
Hygiene: <input type="checkbox"/> Shave <input type="checkbox"/> Deodorant <input type="checkbox"/> Powder <input type="checkbox"/> Lotion								
Nail Care: <input type="checkbox"/> File <input type="checkbox"/> Clean <input type="checkbox"/> Hands <input type="checkbox"/> Feet								
Dressing/Undressing: <input type="checkbox"/> Upper <input type="checkbox"/> Lower								
Elimination: <input type="checkbox"/> Incontinence Care <input type="checkbox"/> Adult Briefs <input type="checkbox"/> Catheter								
Catheter/Ostomy: <input type="checkbox"/> Empty/Change Bag <input type="checkbox"/> Catheter Care								
Toileting: <input type="checkbox"/> Assist <input type="checkbox"/> Urinal/Bed Pan <input type="checkbox"/> BSC <input type="checkbox"/> Empty/Clean BSC								
Ambulation: <input type="checkbox"/> Assist <input type="checkbox"/> Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> WC <input type="checkbox"/> Cane								Distance
Transfer Assistance: <input type="checkbox"/> Stand/Pivot <input type="checkbox"/> Hoyer Lift <input type="checkbox"/> Sliding Board <input type="checkbox"/> Trapeze								
Prosthetics: <input type="checkbox"/> Using a Prosthetic Device								
Support Stockings: <input type="checkbox"/> Remove <input type="checkbox"/> Apply								
Exercise Program: <input type="checkbox"/> Supervising/Coaching/Cueing <input type="checkbox"/> Range of Motion <input type="checkbox"/> Supervised Walks								
Meals: <input type="checkbox"/> Planning <input type="checkbox"/> Prepare B / L / D / Snack <input type="checkbox"/> Ate: G / F / P								Diet:
Food: <input type="checkbox"/> Encourage to Eat <input type="checkbox"/> Feed <input type="checkbox"/> Assist Feeding <input type="checkbox"/> G-Tube								
Fluids: <input type="checkbox"/> Encourage Fluids <input type="checkbox"/> Restrict Fluids								Amount:
Bathroom: <input type="checkbox"/> Clean Sink/Toilet/Tub/Shower <input type="checkbox"/> Mop Floors								
Kitchen: <input type="checkbox"/> Mop <input type="checkbox"/> Sweep <input type="checkbox"/> Dishes <input type="checkbox"/> Trash Removal <input type="checkbox"/> Clean Tabletop								
Bedroom: <input type="checkbox"/> Make Bed <input type="checkbox"/> Change Linens <input type="checkbox"/> Vacuum <input type="checkbox"/> Dust								
Living Room: <input type="checkbox"/> Vacuum <input type="checkbox"/> Sweep <input type="checkbox"/> Dust <input type="checkbox"/> Tidy								
Laundry: <input type="checkbox"/> Wash <input type="checkbox"/> Dry <input type="checkbox"/> Fold <input type="checkbox"/> Iron <input type="checkbox"/> Put Away								
Travel/Transportation: <input type="checkbox"/> Errands <input type="checkbox"/> Groceries/Shopping <input type="checkbox"/> Escort to Dr. Appointment <input type="checkbox"/> Secure Transportation								
Companionship/Support: <input type="checkbox"/> Telephone <input type="checkbox"/> Social/Leisure <input type="checkbox"/> Reading/Writing								
Medications: <input type="checkbox"/> Med Reminder <input type="checkbox"/> Med Assist <input type="checkbox"/> Glucose Monitor Remind								
Miscellaneous: <input type="checkbox"/> Appt Scheduling <input type="checkbox"/> Manage Finances <input type="checkbox"/> Caring for Personal Possessions <input type="checkbox"/> Obtaining Seasonal Clothing								
Reports to Supervisor: <input type="checkbox"/> Change in Status <input type="checkbox"/> Identified Concerns								
Other: _____								
TOTAL HOURS WORKED: REG/OT								

Consumer/Authorized Representative Signs Daily

Date

Employee Signature and Title **Must Sign Daily**

SUN _____	____/____/____	_____
MON _____	____/____/____	_____
TUES _____	____/____/____	_____
WED _____	____/____/____	_____
THURS _____	____/____/____	_____
FRI _____	____/____/____	_____
SAT _____	____/____/____	_____

Please submit by Monday 9:30 am Fax: 614-295-5046/Email: columbustimecards@dedicatednurses.com

In the event of an emergency, Please call your DNA Supervisor at (877) 411-8350