**Personal Care Aide/Homemaker/Companion**

Visit Note

Week Of: / / to \_/ /

A selection MUST be made for each authorized service.

√ = Performed R = Refused

**Incomplete timecards will not be accepted.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **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:** Side Rails Supervise Activity Universal Precautions |  |  |  |  |  |  |  |  |
| **Bathing Assistance:** Tub Shower Bed Bench/Chair |  |  |  |  |  |  |  |  |
| **Oral Care:** Denture Care Brush Teeth Mouthwash |  |  |  |  |  |  |  |  |
| **Hair Care:** Shampoo Comb/Brush Set |  |  |  |  |  |  |  |  |
| **Skin Care:** Skin Care/Lotion Turn/Position Wound Care |  |  |  |  |  |  |  |  |
| **Feet:** Foot Care Lotion Elevate Feet |  |  |  |  |  |  |  |  |
| **Hygiene:** Shave Deodorant Powder Lotion |  |  |  |  |  |  |  |  |
| **Nail Care:** File Clean Hands Feet |  |  |  |  |  |  |  |  |
| **Dressing/Undressing:** Upper Lower |  |  |  |  |  |  |  |  |
| **Elimination:** Incontinence Care Adult Briefs Catheter |  |  |  |  |  |  |  |  |
| **Catheter/Ostomy:** Empty/Change Bag Catheter Care |  |  |  |  |  |  |  |  |
| **Toileting:** Assist Urinal/Bed Pan BSC Empty/Clean BSC |  |  |  |  |  |  |  |  |
| **Ambulation:** Assist Gait Belt Walker WC Cane |  |  |  |  |  |  |  | Distance |
| **Transfer Assistance:** Stand/Pivot Hoyer Lift Sliding BoardTrapeze |  |  |  |  |  |  |  |  |
| **Prosthetics:** Using a Prosthetic Device |  |  |  |  |  |  |  |  |
| **Support Stockings:** Remove Apply |  |  |  |  |  |  |  |  |
| **Exercise Program:** Supervising/Coaching/Cueing Range of MotionSupervised Walks |  |  |  |  |  |  |  |  |
| **Meals:** Planning Prepare B / L / D / Snack Ate: G / F/ P |  |  |  |  |  |  |  | Diet: |
| **Food:** Encourage to Eat Feed Assist Feeding G-Tube |  |  |  |  |  |  |  |  |
| **Fluids:** Encourage Fluids Restrict Fluids |  |  |  |  |  |  |  | Amount: |
| **Bathroom:** Clean Sink/Toilet/Tub/Shower Mop Floors |  |  |  |  |  |  |  |  |
| **Kitchen:** Mop Sweep Dishes Trash RemovalClean Tabletop |  |  |  |  |  |  |  |  |
| **Bedroom:** Make Bed Change Linens Vacuum Dust |  |  |  |  |  |  |  |  |
| **Living Room:** Vacuum Sweep Dust Tidy |  |  |  |  |  |  |  |  |
| **Laundry:** Wash Dry Fold Iron Put Away |  |  |  |  |  |  |  |  |
| **Travel/Transportation:** Errands Groceries/ShoppingEscort to Dr. Appointment Secure Transportation |  |  |  |  |  |  |  |  |
| **Companionship/Support:** Telephone Social/LeisureReading/Writing |  |  |  |  |  |  |  |  |
| **Medications:** Med Reminder Med Assist Glucose MonitorRemind |  |  |  |  |  |  |  |  |
| **Miscellaneous:** Appt Scheduling Manage FinancesCaring for Personal Possessions Obtaining Seasonal Clothing |  |  |  |  |  |  |  |  |
| **Reports to Supervisor:** Change in Status 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: (610)924-7314/Email: AllentownTimecards@dedicatednurses.com In the event of an emergency, Please call your DNA Supervisor at (877) 857-7040