



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

**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: 513-370-5804/Email: [cincinnati@dedicatednurses.com](mailto:cincinnati@dedicatednurses.com)

In the event of an emergency, Please call your DNA Nurse Supervisor at (866)450-5550