

Affiliated Home Care of Putnam
 4 Marina Drive – Suite K1 • Mahopac, NY 10541
 (845) 628-2484 • (845) 628-2507 (fax)
timeslips@homecareputnam.com

Patient Name: _____

Week Ending Date: _____
(always on Sunday)

Aide Name: _____

Aide Signature: _____

Check off services completed on each visit. DO NOT perform any task not indicated in the care plan.

Fill In Dates	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Time Started							
Time Ended							
1. <input type="checkbox"/> Shower <input type="checkbox"/> Bench <input type="checkbox"/> Total <input type="checkbox"/> Assist							
2. <input type="checkbox"/> Sponge/Bedbath <input type="checkbox"/> Total <input type="checkbox"/> Assist							
3. <input type="checkbox"/> Grooming Hair <input type="checkbox"/> Shampoo as needed							
4. <input type="checkbox"/> Dressing <input type="checkbox"/> Total <input type="checkbox"/> Assist							
5. <input type="checkbox"/> Perineal care/diaper change							
6. <input type="checkbox"/> Skin Care <input type="checkbox"/> Observe skin changes							
7. <input type="checkbox"/> Nail Care as needed (file only)							
8. <input type="checkbox"/> Shave as needed (electric razor only)							
9. <input type="checkbox"/> Mouth Care/Denture Care							
10. <input type="checkbox"/> ROM (After RB/PT Instruction)							
11. <input type="checkbox"/> Ambulate with assistance							
12. <input type="checkbox"/> Ambulate <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Crutch							
13. <input type="checkbox"/> Assist with bed pan/urinal/commode/BR							
14. <input type="checkbox"/> HEP (After RN/PT Instruction)							
15. <input type="checkbox"/> Medication Reminders							
16. <input type="checkbox"/> Oxygen <input type="checkbox"/> Continuous <input type="checkbox"/> As needed							
17. <input type="checkbox"/> Catheter care/cleanse around tube/empty bag							
18. <input type="checkbox"/> Make bed and linen change as needed							
19. <input type="checkbox"/> Tidy patient surroundings/kitchen/bath							
20. <input type="checkbox"/> Meal prep <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner							
21. <input type="checkbox"/> Assist/Feed Patient							
22. <input type="checkbox"/> Wash dishes used in meal preparation							
23. <input type="checkbox"/> Personal laundry							
24. <input type="checkbox"/> Transport to medical appt, only if indicated							
25. <input type="checkbox"/> Vacuum/Dust							
26. <input type="checkbox"/> Transfer to chair/wheelchair/commode/bed							
27. <input type="checkbox"/> Weigh patient (see RN instructions)							
28. <input type="checkbox"/> Hoyer Lift <input type="checkbox"/> Slide board							
29. <input type="checkbox"/> Hospital Bed/Side Rails							
30. <input type="checkbox"/> Assist with ostomy bag change							
31. <input type="checkbox"/> Turn and Position							
32. <input type="checkbox"/> Elevate/Position extremities							
33. <input type="checkbox"/> Grocery Shopping/Errands							
34. <input type="checkbox"/> Standard Precaution (Applied Daily)							
Total Visit Time							
Patients Signature							
Comments							

TIME SLIPS ARE DUE IN OFFICE BY MONDAY