Assured Home Nursing Services
Caring for the Community

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HOME HEALTH AIDE WORK RECORD/TIME LOG FOR 7 DAYS

Client Name:							
Year: Month/Day							
Hrs/Shift							
Mileage							
Co-Worker/Client Initials							
☐Total bed bath							
☐Partial Bath							
☐Tub Bath							
☐Shower ☐Shower Seat ☐Flexible Hose							
☐Routine Mouth Care ☐ Denture Care							
☐Shave with Electric Razor ☐ Shave with Razor							
☐Apply Lotion to Dry Skin							
☐Foot Soak							
☐Dress ☐ Street Clothes ☐ Bed Clothes							
☐Comb/Brush Hair							
☐Shampoo ☐ In Bed ☐ At Sink ☐ Shower							
☐Bed Rest ☐ Turn q 2°							
☐Assist with Ambulation Frequency_____ Device_____							
☐ROM as specified by PT or SN							
☐Toilet: ☐ Bedpan ☐ Commode ☐ Urinal							
☐Empty Urinary Drainage Container or Bag							
☐Clean and Rinse Ostomy Bag prn							
☐Monitor Bowel Movements							
☐Assist with Medications ☐ Remind Client							
☐ Check Medication Cassette							
☐Vital Signs & Record							
☐Sweep ☐ Vacuum ☐Dust							
☐Wash Dishes ☐ Mop Kitchen Floor (Sponge Mop Only)							
☐Clean Bathroom ☐ Wipe Mirror ☐Rinse Tub							
☐Change Linen ☐Wash Clothes							
☐Prepare Meals ☐ Monitor Appetite							
☐ Safety Precautions ☐ Clear Pathways ☐ Adequate Lighting							
☐ Oxygen Precautions ☐ Universal Precautions							
☐ Seizure Precautions							
☐ Aspiration Precautions							
☐Transportation Required							

☐Observations/Treatments: _____

☐Notified office of any condition change: _____

Comments: _____

_____

Employee signature: _____ Client Signature: _____

Title: _____