GOOD SHEPHERD HOSPICE
HOME HEALTH AIDE SERVICE REPORT

Patient _____ PID# _____

	DATE/YEAR								
	TIME ARRIVED								
	TIME OF LEAVING								
*	INTERRUPTION IN CARE TIME (minutes)								
10	Mouth Care								
11	Bath/Shower per care plan								
12	Home Exercise Program								
13	Apply Lotion								
14	Shampoo Hair as needed								
15	Clean Nails								
16	Shave Per Care Plan								
17	Dress Patient								
18	Toileting Per Care Plan								
19	Empty Foley bag								
20	Feeding per care plan								
21	Meal Preparation								
22	Encourage Fluids								
23	Ambulation Per Care Plan								
24	Transfer Per Care Plan								
25	Turn and Position								
26	Elevate Legs								
27	Wash Dishes Used								
28	Change & Make Bed								
29	Laundry								
30	Equipment/Devices								
31	Other:								

Agency Name:

Community Care
~~300 West Main St.~~
Smithtown, NY 117

Call nurse or supervisor if any changes in patient condition are reported to you and/or noticed by you.

REMEMBER:
Use Standard Precautions & PPE as indicated

KEY

✓ **IF CARE PERFORMED**

P - PATIENT PERFORMS

F - FAMILY PERFORMS

RS -REFUSES SERVICES

* **INTERRUPTION IN CARE TIME:**

More than 15 min. no care provided because patient
-was on phone
or
- received visitor

SIGNATURE:

PT HHA PT HHA PT HHA PT HHA PT HHA PT HHA PT HHA

Visit Verification:
Patient/Caregiver must sign each day

Revision 1/28/14