OUR LADY OF CONSOLATION LONG TERM HOME CARE
HOME HEALTH AIDE SERVICE REPORT

Patient _____ **PID#** _____

Agency Name: COMMUNITY CARE

	DATE/YEAR							
	TIME ARRIVED							
	TIME OF LEAVING							
*	INTERRUPTION IN CARE TIME (minutes)							
1	Mouth Care							
2	Bath							
3	Shower							
4	Home Exercise Plan							
5	Lotion							
6	Shampoo Hair							
7	Clean Nails							
8	Shave Per Care Plan							
9	Dress Patient							
10	Toileting Per Care Plan							
11	Feeding							
12	Meal Preparation							
13	Encourage Fluids							
14	Ambulate Per Care Plan							
15	Transfer Per Care Plan							
16	Turn and Position							
17	Elevate Legs							
18	Housekeeping							
19	Laundry							
20	Change & Make Bed							
21	Reminder(s)							
22	Other:							
23	Other:							

SIGNATURE: PT / HHA PT / HHA PT / HHA PT / HHA PT / HHA PT / HHA PT / HHA

Visit Verification:
Patient/Caregiver must sign each day

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

REMEMBER:
Use Standard Precautions & PPE as indicated

<u>KEY</u>

✓ IF CARE PERFORMED

P - PATIENT PERFORMS

F - FAMILY PERFORMS

RS -REFUSES SERVICES

NN – NOT NEEDED

*** INTERRUPTION IN CARE TIME:**
More than <u>15 min.</u> <u>no care</u> provided because patient
-was on phone
or
- received visitor