

TIME SHEET

Patient's Name _____
 Patient's Phone _____
 Address _____
 City/State/Zip _____

Field Aide _____
 Field Aide Signature _____
 Phone _____

TIME SLIP

WEEK ENDING DATE

| Day | Date MM/DD/YY | Start Time | AM/ PM | End Time | AM/ PM | Total Hours | Emp. Init. | Client signature | | | | |
|--|---------------|------------|----------|----------|--------|-------------|------------|------------------|------|-----|-------|-----|
| SAT | | | | | | | | | | | | |
| SUN | | | | | | | | | | | | |
| MON | | | | | | | | | | | | |
| TUES | | | | | | | | | | | | |
| WEDS | | | | | | | | | | | | |
| THURS | | | | | | | | | | | | |
| FRI | | | | | | | | | | | | |
| BATHING | | | COMMENTS | | | SAT | SUN | MON | TUES | WED | THURS | FRI |
| <input type="checkbox"/> Total Bed Bath | | | | | | | | | | | | |
| <input type="checkbox"/> Assist Bed Bath | | | | | | | | | | | | |
| <input type="checkbox"/> Assist Shower | | | | | | | | | | | | |
| <input type="checkbox"/> Assist Tub | | | | | | | | | | | | |
| PERSONAL | | | | | | | | | | | | |
| <input type="checkbox"/> Shampoo/Hair Care | | | | | | | | | | | | |
| <input type="checkbox"/> Mouth Care | | | | | | | | | | | | |
| <input type="checkbox"/> Skin Care | | | | | | | | | | | | |
| <input type="checkbox"/> Assist w/ Dressing | | | | | | | | | | | | |
| <input type="checkbox"/> Shave | | | | | | | | | | | | |
| <input type="checkbox"/> Nail Care | | | | | | | | | | | | |
| <input type="checkbox"/> Pedicure | | | | | | | | | | | | |
| MOBILITY | | | | | | | | | | | | |
| <input type="checkbox"/> Assist w/ Ambulation | | | | | | | | | | | | |
| <input type="checkbox"/> Assist to Bed | | | | | | | | | | | | |
| <input type="checkbox"/> Assist w/ Turning | | | | | | | | | | | | |
| NUTRITION | | | | | | | | | | | | |
| Diet: <input type="checkbox"/> Regular | | | | | | | | | | | | |
| <input type="checkbox"/> Low Na+ | | | | | | | | | | | | |
| <input type="checkbox"/> Diabetic | | | | | | | | | | | | |
| <input type="checkbox"/> Other: _____ | | | | | | | | | | | | |
| <input type="checkbox"/> Prepare Meal | | | | | | | | | | | | |
| <input type="checkbox"/> Serve Meal | | | | | | | | | | | | |
| <input type="checkbox"/> Assist w/ Feeding | | | | | | | | | | | | |
| <input type="checkbox"/> Encourage Fluids | | | | | | | | | | | | |
| <input type="checkbox"/> Other: _____ | | | | | | | | | | | | |
| TOILETING-ELIMINATION | | | | | | | | | | | | |
| <input type="checkbox"/> Urinal/Bedpan/Commode | | | | | | | | | | | | |
| <input type="checkbox"/> Empty Catheter Bag | | | | | | | | | | | | |
| <input type="checkbox"/> Incontinent Care | | | | | | | | | | | | |
| <input type="checkbox"/> Last Bowel Movement | | | | | | | | | | | | |
| Date: _____ | | | | | | | | | | | | |
| <input type="checkbox"/> Other: _____ | | | | | | | | | | | | |
| HOUSEKEEPING | | | | | | | | | | | | |
| <input type="checkbox"/> Laundry | | | | | | | | | | | | |
| <input type="checkbox"/> Clean Bedroom | | | | | | | | | | | | |
| <input type="checkbox"/> Clean Bathroom | | | | | | | | | | | | |
| <input type="checkbox"/> Change/Make Bed | | | | | | | | | | | | |
| <input type="checkbox"/> Clean Kitchen | | | | | | | | | | | | |
| <input type="checkbox"/> Wash Dishes | | | | | | | | | | | | |
| <input type="checkbox"/> Vacuum/Sweep | | | | | | | | | | | | |
| <input type="checkbox"/> Grocery Shopping | | | | | | | | | | | | |