Client's Name: _____

	Date					
	Time In					
	Time Out					
	Mileage					
Client Cognition (Oriented/Clear/Confused/Agitated)						
Medications (Note only regularly scheduled medications)						
Breakfast meds taken						
Lunch meds taken						
Dinner meds taken						
Nighttime meds taken						
Kitchen						
Cleaned counters						
Cleaned floors						
Cleaned refrigerator						
Dishes						
Bathroom						
Cleaned sink						
Cleaned toilet						
Cleaned tub						
Cleaned floors						
Bedroom						
Cleaned floors						
Dusted						
Made Bed						
Changed linens						
Living Room						
Cleaned floors						
Dusted						
Laundry						
Folded clothes and put away						
Meals						
Assisted with Meal Planning						
Prepared (Please use code: B L or D)						
Was Cueing Necessary (Y or N)						
Grocery Shopping						
Transportation						
Drs Appointment (any follow up appts please call the office)						
Errands						

Please use these codes to indicate I= independent A=provided assistance

Personal Care					
Bath/Shower (I or A)					
Sponge Bath (I or A)					
Shampoo Hair (I or A)					
Skin Care (I or A)					
Any Sores or other reportable condition? Y or N- (please call the office if condition is new or worsening)					
Shave (electric razor only) (I or A)					
Mouth Care/Teeth Brushing (I or A)					
Dressing Assistance					
Nail Care (cleaning only) (I or A)					
Toileting					
Urinal/Bedpan/Commode: please indicate which if any					
Transfer to toilet/commode (I or A)					
Incontinence Assistance					
Ambulation					
Walking Assistance					
Asst with Transfer (bed,chair)					
Device: please indicate walker, wheelchair, cane					
CAREGIVER INITIALS					

Nutrition (include fluids)

Date:
Brkfst:
Lunch:
Dinner:
Date:
Brkfst:
Lunch:
Dinner:
Date:
Brkfst:
Lunch:
Dinner:

Date:
Brkfst:
Lunch:
Dinner:
Date:
Brkfst:
Lunch:
Dinner:

Notes: **Please limit your notes to important, objective information that the next CAREGiver, family member, or staf may find helpful- please date and sign any and all notes**