ATRIUM HOME & HEALTHCARE SERVICES, INC.
WEEKLY HOME HEALTH AIDE NOTE

Client Name: _____ *MR#:* _____

For Week Ending (Saturday 12mn): ____/____/____

Day of Week	Date	Time In	Time Out	Time In	Time Out	Total Hours	Client Signature
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							

Total Hours For Week:

√=Care Given R= Refused Care

	S	M	T	W	T	F	S
TUB / SHOWER							
Tub Bath w/ chair							
Shower w/ chair							
Remove Dressing & Re-Apply							
PARTIAL/COMPLETE BATH							
Complete Bed Bath							
Partial Bed Bath: Tub Sink							
PERSONAL CARE							
Brush / Comb / Style Hair							
Shampoo: Bed Sink Tub							
Pericare							
Back / Skin Care							
Nails: Soak / File / Clean							
Shave							
Oral Hygiene							
Denture Care							
Foot Care: Soak / File / Clean							
Dress							
CATHETER CARE							
Indwelling Catheter Care							
Record Urine Output							
Empty Drainage Bag							
Straight Catherize Q ____ Hrs							
MEALS							
Prepare Meal							
Feed							
Encourage Fluid/Supplement							

	S	M	T	W	T	F	S
ACTIVITY							
Remain in Bed							
Reposition							
Elevate Head of Bed							
Ambulate with Assist							
Up in Chair							
Transfer Bed/Chair							
EXERCISES							
ROM Exercise							
GROCERY							
Light Grocery Patient ONLY							
LAUNDRY							
Light Laundry Patient ONLY							
LIGHT HOUSEKEEPING							
Change Bed Linen							
Make Bed							
Light Housekeeping							
OTHER							
Assist with Bed Pan							
Assist to Bathroom							
Assist Bedside Commode							
Administer Enema/Suppository							
Medication Reminder							
Transportation							

Employee Signature: **Date:**

White Copy - Office Yellow Copy- Patient Pink Copy - Employee