PREMIER CARE NURSES OF AMERICA
CNA/HHA HOME HEALTH CARE REPORT

Client Name: _____ Week: From: ___/___/___ To: ___/___/___

	SUN	MON	TUES	WED	THUR	FRI	SAT
Date	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Time In (please circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out (please circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
IF YOU WORK TWO SHIFTS A DAY FOR *ONE* PATIENT PUT *SECOND SHIFT ONLY BELOW*							
Time In (please circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out (please circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM

PLEASE CHECK ([) ANY ASSISTANCE YOU GAVE TO PATIENT

PERSONAL CARE	SUN	MON	TUES	WED	THURS	FRI	SAT
SHOWER							
TUB BATH							
BED BATH							
SKIN CARE							
SHAMPOO							
SHAVE CLIENT							
MOUTH CARE							
ASSIST TO DRESS							
EATING							
SET UP MEAL							
FEED PATIENT							
TOILETING							
ASSIST TO TOILET							
BED PAN/URINAL							
TRANSFER TO COMMODE							
DIAPER							
FOLEY/CATHETER/COLOSTOMY							
RECORD BOWEL MOVEMENT							
ACTIVITY							
ASSIST TO WALK							
ASSIST WITH WALKER/CANE							
ASSIST WITH WHEELCHAIR							
BEDREST							
LIFT (DEVICE)							
RANGE OF MOTION							
REPOSITION							
HOME MANAGEMENT							
REMIND TO TAKE MEDS							
CLEAN BATHROOM							
CLEAN BEDROOM/HOUSE							
LAUNDRY							
GROCERY SHOP							
MAINTAIN SAFETY							
OFFICE USE ONLY							
FIRST SHIFT							
SECOND SHIFT							
TOTAL HOURS							

Client Signature: X_____ Caregiver Signature: X_____

I certify the hours and duties indicated above are correct

*CARE GIVER, PLEASE CALL NURSING SUPERVISOR WITH ANY CHANGES IN THE PATIENT'S CONDITION OR MEDICATION(S

FILL OUT DAILY AND FAX WITH TIME SHEET

Sunday:

Monday:

Tuesday:

Wednesday:

Thursday:

Friday:

Saturday: