

# REVIVAL HOME HEALTH CARE INC.

# HOME HEALTH AIDE DUTY SHEET

Instructions: Check (✓) off all completed tasks. Complete all tasks which are either checked or noted on patient Plan of Care.

Emp.Name: \_\_\_\_\_

Pt. Name \_\_\_\_\_

Agency \_\_\_\_\_ Coord. \_\_\_\_\_

Address \_\_\_\_\_

SS# \_\_\_\_\_ Emp.# \_\_\_\_\_

Phone \_\_\_\_\_ PT ID \_\_\_\_\_ Year \_\_\_\_\_

1. <b>USE BLACK INK ONLY.</b> 2. Fill this form out every day that you visit this patient. 3. You and the patient must sign daily. 4. In case of a patient emergency, call 911 and then notify Revival at <b>(718) 853-2500</b> 5. Mail or bring this form to your Agency every Friday.	PUT DATE VISITED IN EACH BOX	SAT	SUN	MON	TUES	WED	THUR	FRI
		/	/	/	/	/	/	/
	TIME ARRIVED IN PATIENT'S HOME	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
	TIME LEFT PATIENT'S HOME	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
	TOTAL HOURS WORKED							

PERSONAL CARE		S	S	M	T	W	T	F	TREATMENTS/SPECIAL NEEDS		S	S	M	T	W	T	F
BATH	TUB								TAKE TEMPERATURE: <input type="checkbox"/> ORAL <input type="checkbox"/> RECTAL <input type="checkbox"/> AXILLARY								
<input type="checkbox"/> TOTAL CARE	SHOWER								TAKE PULSE								
<input type="checkbox"/> ASSIST	BED								TAKE RESPIRATIONS								
MOUTH CARE/DENTURE CARE									TAKE BLOOD PRESSURE								
HAIR CARE	COMB								WEIGH PATIENT								
	SHAMPOO								RECORD OUTPUT (URINE/BM)								
GROOMING	SHAVE								ASSIST WITH CATHETER CARE								
	NAILS								EMPTY FOLEY BAG								
DRESSING									ASSIST WITH OSTOMY CARE								
SKIN CARE									REMIND TO TAKE MEDICATION								
FOOT CARE									ASSIST WITH TREATMENTS, SPECIFY AS WRITTEN ON POC:								
TOILETING: <input type="checkbox"/> DIAPER <input type="checkbox"/> COMMODE <input type="checkbox"/> BEDPAN/URINAL <input type="checkbox"/> TOILET									CHANGE BED LINEN								
NUTRITION		PATIENT SUPPORT ACTIVITIES															
DIET: <input type="checkbox"/> REGULAR <input type="checkbox"/> PRESCRIBED									DO PATIENT LAUNDRY								
PREPARE: <input type="checkbox"/> BREAKFAST <input type="checkbox"/> LUNCH <input type="checkbox"/> DINNER									LIGHT HOUSEKEEPING: <input type="checkbox"/> PATIENT ROOM <input type="checkbox"/> KITCHEN <input type="checkbox"/> BATHROOM <input type="checkbox"/> PATIENT CARE EQUIPMENT								
PREPARE SNACK									DO PATIENT SHOPPING								
ASSIST WITH FEEDING									DO PATIENT ERRANDS								
RECORD INTAKE: <input type="checkbox"/> FOOD <input type="checkbox"/> FLUID									ACCOMPANY PATIENT TO MEDICAL APPOINTMENT								
ACTIVITY									DIVERSIONAL ACTIVITIES-SPECIFY : <input type="checkbox"/> READING <input type="checkbox"/> TALKING								
TRANSFER									MONITOR PATIENT SAFETY								
ASSIST WITH WALKING									UNIVERSAL PRECAUTIONS								
DEVICE IN USE: <input type="checkbox"/> CANE <input type="checkbox"/> WALKER <input type="checkbox"/> CRUTCHES									PATIENT UNABLE TO SIGN								
ASSIST WITH HOME EXERCISE PROGRAM																	
ASSIST WITH RANGE OF MOTION EXERCISES: <input type="checkbox"/> R Arm <input type="checkbox"/> L Arm <input type="checkbox"/> R Foot <input type="checkbox"/> L Foot <input type="checkbox"/> Neck																	
TURNING AND POSITIONING (AT LEAST Q2H)																	

	PATIENT / CAREGIVER	HHA SIGNATURE		PATIENT / CAREGIVER	HHA SIGNATURE
SAT.			WED.		
SUN.			THUR.		
MON.			FRI.		
TUES.			RN		