

 <p>PARAPROFESSIONAL DUTY SHEET</p>	PATIENT NAME (Last, First)	Medical Record #
	ADDRESS	Zip
	<input type="checkbox"/> Queens <input type="checkbox"/> Long Island <input type="checkbox"/> Brooklyn <input type="checkbox"/> Manhattan <input type="checkbox"/> Staten Island <input type="checkbox"/> Bronx	<input type="checkbox"/> CHHA <input type="checkbox"/> OTHER <input type="checkbox"/> LTHHCP <input type="checkbox"/> IV Therapy

Employee Name _____ Last _____ First _____ Employee SS# _____

HHA Level of Care PCA Level of Care Homemaker/Housekeeper

Frequency of Service: _____ Days _____ Hours X _____ Weeks/Month

OFFICE USE ONLY

Vendor: _____

Hrs. _____ ID: _____

The patient and you must sign each day to verify the care has been given: (Do not print)								
	Date	Patient Signature	Aide Signature	Time In	Time Out	Total Time	Office use only	
							Personal Care	Other Activity
Saturday								
Sunday								
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								

CARE TO BE PROVIDED	DAY							Standard Precautions-ALL PATIENTS
	FREQUENCY OF TASKS AS PER PLAN OF CARE	S	S	M	T	W	T	
Bathing <input type="checkbox"/> Tub <input type="checkbox"/> Shower <input type="checkbox"/> Sponge								
Personal Care Mouth Care <input type="checkbox"/> Dentures Comb/Brush Hair Shampoo <input type="checkbox"/> PRN Shave <input type="checkbox"/> PRN Foot Care Nail Care Skin Care (Specify) Dressing/Grooming <input type="checkbox"/> Partial <input type="checkbox"/> Total								
Toileting <input type="checkbox"/> Bathroom <input type="checkbox"/> Commode <input type="checkbox"/> Urinal <input type="checkbox"/> Bedpan Incontinence Care Bowel Movement – Record								
Catheter Care Empty Catheter Bag Perineal Care Catheter Care								
Ambulation and Transfers <input type="checkbox"/> Independent <input type="checkbox"/> Assist Bedbound/Reposition <input type="checkbox"/> Chair/Wheelchair <input type="checkbox"/> Commode <input type="checkbox"/> Walker <input type="checkbox"/> Crutches <input type="checkbox"/> Cane								
Exercises ROM Exercises Assist with PT/OT Plan								
Prepare Meal Diet (Specify) Prepare Meal/Snack Feed/Assist Eating Reinforce Diet Instructions Encourage Fluids Record Intake/Record Output								
Grocery Shop <input type="checkbox"/> Grocery Shop <input type="checkbox"/> Errands								
Laundry <input type="checkbox"/> Laundromat <input type="checkbox"/> Machine in Home								
Housekeeping <input type="checkbox"/> Bathroom <input type="checkbox"/> Patient Area <input type="checkbox"/> Kitchen								
Vital Signs Temperature <input type="checkbox"/> Oral <input type="checkbox"/> Axillary <input type="checkbox"/> Weight								
Other Wound Care <input type="checkbox"/> Reinforce dressing Ostomy Care (Specify) Remind Medications Accompany to <input type="checkbox"/> MMD <input type="checkbox"/> Other (Specify)								

Supervise Patient Safety
Comments : _____