

ANGEL CARE, INC.

1580 Dahill Rd., 2nd Floor, BROOKLYN, NY 11204 TEL: 917-507-7500, FAX: 917-507-7501

PERSONAL CARE AIDE TIME AND DUTY REPORT- USE BLACK INK ONLY. MUST SUBMIT ORIGINAL

| | |
|---------------------------|----------------------------------|
| Patient Full Name: | Employee Full Name: |
| Patient Address: | Week Ending: / /20____ |

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|---|------------|------------|------------|------------|------------|------------|------------|
| Date of Service | / | / | / | / | / | / | / |
| Time In (am/pm) | | | | | | | |
| Time Out (am/pm) | | | | | | | |
| Hours worked | | | | | | | |
| TASK/ACTIVITY | SAT | SUN | MON | TUE | WED | THU | FRI |
| <input type="checkbox"/> Bed ¹⁰² <input type="checkbox"/> Tub ¹⁰⁰ <input type="checkbox"/> Shower ¹⁰¹ <input type="checkbox"/> Total Care ¹⁰³ | | | | | | | |
| Hair Care: <input type="checkbox"/> Shampoo ¹⁰⁸ <input type="checkbox"/> Comb/Brush ¹⁰⁷ | | | | | | | |
| <input type="checkbox"/> Shave ¹⁰⁹ <input type="checkbox"/> Nail care ¹¹⁰ (DO NOT CUT NAILS) | | | | | | | |
| <input type="checkbox"/> Oral Hygiene/Mouth Care ¹⁰⁶ <input type="checkbox"/> Denture Care ¹⁰⁶ | | | | | | | |
| Skin Care: <input type="checkbox"/> Lotion ¹¹² <input type="checkbox"/> Observation of skin condition ⁵⁴⁴ | | | | | | | |
| Foot Care¹¹³ | | | | | | | |
| Dressing: <input type="checkbox"/> Total ¹¹¹ <input type="checkbox"/> Assist ¹¹¹ | | | | | | | |
| Meals: <input type="checkbox"/> Breakfast ²⁰² <input type="checkbox"/> Lunch ²⁰³ <input type="checkbox"/> Dinner ²⁰⁴ <input type="checkbox"/> Snack ²⁰⁵ | | | | | | | |
| <input type="checkbox"/> Assist/Feed Patient ²⁰⁶ <input type="checkbox"/> Patient is on Prescribed Diet ²⁰¹ | | | | | | | |
| Diet: <input type="checkbox"/> Low/No Salt ⁵³⁰ <input type="checkbox"/> Low fat ⁵³² <input type="checkbox"/> Low Cholesterol ⁵³³ <input type="checkbox"/> Renal ⁵³⁶ <input type="checkbox"/> ADA Calories ⁵³⁵ <input type="checkbox"/> Fluid Restriction ⁵³⁷ <input type="checkbox"/> No Concentrated Sweets ⁵³⁴ | | | | | | | |
| Ambulation: <input type="checkbox"/> Assist ³⁰¹ <input type="checkbox"/> Cane ³⁰² <input type="checkbox"/> Walker ³⁰² <input type="checkbox"/> Wheelchair ³⁰² | | | | | | | |
| Transfer: <input type="checkbox"/> Bed ³⁰⁰ <input type="checkbox"/> Chair ³⁰⁰ | | | | | | | |
| <input type="checkbox"/> Turn Q2hours ³¹¹ | | | | | | | |
| <input type="checkbox"/> Ostomy ⁴¹⁰ / Catheter Care ⁴⁰⁸ <input type="checkbox"/> Empty Foley Bag ⁴⁰⁹ <input type="checkbox"/> Assist with treatment ⁴¹² <input type="checkbox"/> Clean Pt care equipment ⁵⁰⁵ | | | | | | | |
| <input type="checkbox"/> Toilet ¹¹⁷ <input type="checkbox"/> Commode ¹¹⁵ <input type="checkbox"/> Urinal/Bedpan ¹¹⁶ <input type="checkbox"/> Diaper ¹¹⁴ | | | | | | | |
| Medications: <input type="checkbox"/> Assist ⁴¹¹ <input type="checkbox"/> Remind ⁴¹¹ | | | | | | | |
| <input type="checkbox"/> Observe /Report Physical/Mental Changes | | | | | | | |
| <input type="checkbox"/> Linen Change ⁵⁰⁰ <input type="checkbox"/> Laundry ⁵⁰¹ <input type="checkbox"/> Light Housekeeping ⁵⁰² | | | | | | | |
| <input type="checkbox"/> Shopping/Errands ⁵⁰⁶ <input type="checkbox"/> Escort to Appointments ⁵⁰⁸ | | | | | | | |
| <input type="checkbox"/> Monitor Patient Safety ⁵¹¹ <input type="checkbox"/> Diversional Activities-Speak/Read ⁵⁰⁹ | | | | | | | |
| <input type="checkbox"/> Standard Precautions ⁵⁴² <input type="checkbox"/> Fall Precautions ⁵³⁹ <input type="checkbox"/> Seizure Precautions ⁵⁴⁰ <input type="checkbox"/> Bleeding Precautions ⁵⁴¹ <input type="checkbox"/> Oxygen Precautions ⁵⁴³ | | | | | | | |
| HHA AND AHHA ONLY (UNDER SUPERVISION OF RN OR PT) | | | | | | | |
| <input type="checkbox"/> ROM ³⁰⁶ <input type="checkbox"/> Exercise Program ³⁰⁵ : (As per PT Inst.) | | | | | | | |
| <input type="checkbox"/> Non-Sterile Dressing | | | | | | | |
| Record <input type="checkbox"/> Food Intake ²⁰⁷ <input type="checkbox"/> Fluid Intake ²⁰⁸ <input type="checkbox"/> Urine/BM Output ⁴⁰⁷ | | | | | | | |
| <input type="checkbox"/> Record Temperature ⁴⁰⁰ <input type="checkbox"/> Record Weight ⁴⁰⁶ <input type="checkbox"/> Record Pulse ⁴⁰³ <input type="checkbox"/> Record Respiration ⁴⁰⁴ <input type="checkbox"/> Take Blood Pressure ⁴⁰⁵ | | | | | | | |

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| Employee/HHA Signature: | Date: |
| Patient/Family Representative Signature: | Date: |

**Please note that all fields must be completed. Timesheets must be submitted by no later than Wednesday at 5pm or it will not be processed with the current week payroll. Please call the office to make sure your timesheet was received or to request blank timesheets. **