|  |  |  |  |
| --- | --- | --- | --- |
| **Consumer’s Name(print clearly)** |  | **Employee’s Name** |  |
|  **DAY DATE** | **TIME IN** | **TIME OUT** | **TOTAL HOURS** | **CONSUMER SIGNATURE** |
| Sunday |  |  |  |  |  |
| Monday  |  |  |  |  |  |
| Tuesday  |  |  |  |  |  |
| Wednesday |  |  |  |  |  |
| Thursday |  |  |  |  |  |
| Friday |  |  |  |  |  |
| Saturday |  |  |  |  |  |
| **Employee Signature** |  | **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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**ANASTASIA CARE SERVICES LLC**

**WEEKLY ACTIVITY RECORD OFFICE COPY/CLIENT COPY**

Complete on each visit. Report any changes to Supervisor. Do ONLY what is on care plan.

|  |  |  |  |
| --- | --- | --- | --- |
| **Consumer’s Name****(print clearly)** |  | **Week Ending** |  |
| **Employee’s Name (print clearly)** |  |
| **Time Sheet***You must print clearly and total your hours* |  | **Sun** | **Mon** | **Tue** | **Wed** | **Thu** | **Fri** | **Sat** | **Additional Comments** |
| **Date ⇨** |  |  |  |  |  |  |  |  |
| **Time In ⇨** |  |  |  |  |  |  |  |  |
| **Time Out ⇨** |  |  |  |  |  |  |  |  |
| **Total Hours ⇨** |  |  |  |  |  |  |  |  |
| **PERSONAL CARE AND ACTIVITIES** | BATH 🞎 Bed 🞎 Shower 🞎 Tub |  |  |  |  |  |  |  |  |
| Shampoo/Hair Care |  |  |  |  |  |  |  |  |
| Mouth care |  |  |  |  |  |  |  |  |
| Dress |  |  |  |  |  |  |  |  |
| Shave |  |  |  |  |  |  |  |  |
| Observe & report changes in skin |  |  |  |  |  |  |  |  |
| Skin breakdown or reddened areas |  |  |  |  |  |  |  |  |
| Special skin Care |  |  |  |  |  |  |  |  |
| Nail Care 🞎 Fingers 🞎 Toes |  |  |  |  |  |  |  |  |
| Transfer activity |  |  |  |  |  |  |  |  |
| Walking |  |  |  |  |  |  |  |  |
| Up with help |  |  |  |  |  |  |  |  |
| Foot care |  |  |  |  |  |  |  |  |
| Encourage fluids |  |  |  |  |  |  |  |  |
| Feeding |  |  |  |  |  |  |  |  |
| Incontinence care |  |  |  |  |  |  |  |  |
| Report loss of appetite |  |  |  |  |  |  |  |  |
| Report difficulty or pain upon urination |  |  |  |  |  |  |  |  |
| Empty catheter bag |  |  |  |  |  |  |  |  |
| Record intake and output |  |  |  |  |  |  |  |  |
| Record bowel movements |  |  |  |  |  |  |  |  |
| Assist with commode, urinal, bedpan, toilet |  |  |  |  |  |  |  |  |
| Reinforce non sterile dressing—to a stable wound surface |  |  |  |  |  |  |  |  |
| Take vital signs—record on service report |  |  |  |  |  |  |  |  |
| Empty ostomy pouch |  |  |  |  |  |  |  |  |
| **HOME TASKS** | Prepare and serve meal and/or snack |  |  |  |  |  |  |  |  |
| Laundry |  |  |  |  |  |  |  |  |
| Clean client’s bathroom |  |  |  |  |  |  |  |  |
| Change/make bed |  |  |  |  |  |  |  |  |
| Clean kitchen |  |  |  |  |  |  |  |  |
| Wash dishes |  |  |  |  |  |  |  |  |
| Vacuum/Sweep/Mop/Dust |  |  |  |  |  |  |  |  |
| Grocery shopping/Run errands |  |  |  |  |  |  |  |  |
| Ironing |  |  |  |  |  |  |  |  |
| Clean consumer’s bedroom |  |  |  |  |  |  |  |  |
| **ALL** | Maintain safety—See instructions at right |  |  |  |  |  |  |  |  |
| Accompany consumer to MD office/appt. |  |  |  |  |  |  |  |  |
| Diversional activities/Socialization |  |  |  |  |  |  |  |  |
| Honor Bill of Rights |  |  |  |  |  |  |  |  |
| Observe Universal Precautions |  |  |  |  |  |  |  |  |
|  | **Client’s Initials** |  |  |  |  |  |  |  |  |
|  |
| Supervisor’s Signature Initials Date |
| Consumer’s Signature Initials Date |
| Home Health Aide/Homemaker/Companion’s Signature Initials Date­­­ |