|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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  ­­­ | | | | | | | | | | | | | | |