REORDER FROM FIRST FORMS 215-355-6663 129494-BT

PROTOCALL™ HOME HEALTH AIDE TIME & ACTIVITY RECORD/PLAN OF CARE

Clients Name: ______________________ Client's Address: ______________________

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Enter Month/Date ☞	/	/	/	/	/	/	/
Time Arrived							
(In-Out) Break Time							
Time Left							
Total Time Worked							
Authorized Client Initials ☞							

EMPLOYEE INFORMATION:
I hereby verify that the hours shown herein were worked by me during the week ending designated, and were certified by an authorized rep of the client. I understand that if any assignment is complete. I must contact Protocall for additional work and if I do not do so, I am not available for additional assignments. Furthermore, I certify that I have not sustained any work-related injuries during this assignment.

Week Ending Date (Sunday)

Month / Day / Year

Total Time Worked For Week: ______

I agree that the times listed and the services performed are accurate. I also agree to the terms on the back.

✗ ______________________ Employee Signature

✗ ______________________ Authorized Client Signature

Activity	Frequency		Mon	Tues	Wed	Thurs	Fri	Sat	Sun
		DRESSING: PERSONAL ASSISTANCE							
		Bath: Bed/Tub/Shower							
		Clean & File Nails, Soak Feet, Apply Lotion							
		Hair Grooming, Shampoo, Shaving							
		Mouth, Denture Care							
		Bladder Care, Bowel Care, Incontinence Care							
		Special Skin Care							
		TREATMENTS:							
		Assist with oral medications							
		Foley Care: Hygiene Assist with drainage bag							
		Urine Testing							
		Assist Ostomy Bag							
		Change Dressings							
		Intake and Output							
		Other: Vital Signs (record findings)							
		Temperature							
		Pulse							
		Respiration							
		ACTIVITY:							
		Bedrest Positioning							
		Transfer to Bed/Chair							
		Transfer using Hoyer Lift							
		Ambulation with Assistance							
		Wheelchair/Walker/Cane/Crutches							
		Exercises - range of motion							
		Assistance with Home PT Program							
		Assistance with Home OT Program							
		Assistance with Home ST Program							
		Other							
		DIETARY:							
		Special Diet Preparation							
		Meal Planning							
		Feed Meals							
		Encourage Fluids							
		Fluid Restriction							
		HOME MANAGEMENT:							
		Shopping/Errands							
		Essential Laundering							
		Dusting/Vacuuming							
		Clean Dishes, Stove, Refrigerator							
		Care of Sick Rm/Bed Making/change linen							

PROTOCALL™

NOTE CHANGE IN CLIENT CONDITION: ______________________

DATE/TIME: ______________________ **REPORTED TO:** ______________________

PROBLEM: ______________________

OUTCOME: ______________________

SUPERVISOR SIGNATURE: ______________________ **DATE:** ______________________

ACCOUNTING