SeniorCare
Home Health Agency, Inc.
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HHA/PCA VISIT RECORD

PATIENT'S NAME: _____ PHONE #: _____

PATIENT'S ADDRESS: _____

CAREGIVER'S NAME: _____ CAREGIVER'S #: _____

Check each block for care provided that day as directed from Aide Care Plan.
Mark the block with "R" if the Patient refused the care. Fill in each date under each day serviced.

ASSIGNMENT / TASKS		SAT	SUN	MON	TUE	WED	THU	FRI
DATE / YEAR		/	/	/	/	/	/	/
BATH:	☐ Complete ☐ Partial ☐ Bed							
	☐ Tub ☐ Shower ☐ Sponge							
	☐ Skin Care ☐ Foot Care							
NAIL CARE:	☐ Clean/File							
SHAVE:	☐ Electric ☐ Safety Razor							
HAIR:	☐ Shampoo ☐ Brush/Comb							
ORAL CARE:	☐ Teeth ☐ Dentures							
DRESS:	☐ Self ☐ Assist ☐ Total							
TRANSFERS:	☐ 1-person ☐ 2-person							
	☐ Board ☐ Mechanical Lift							
WALKING:	☐ Assist ☐ Supervise							
DEVICE:	☐ Cane ☐ Walker ☐ Crutches							
REPOSITION:	☐ PRN ☐ Bed ☐ W/C							
TOILETING:	☐ Bathroom ☐ Commode							
	☐ Bedpan ☐ Urinal ☐ Diaper							
	☐ Catheter Care ☐ Empty Drainage Bag							
INCONTINENT CARE:	☐ Bladder ☐ Bowel							
DIET INSTRUCTION:	☐ Reinforce Diet ☐ Feed Patient							
	☐ Assist with Feeding							
PREPARE MEALS:	☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snack							
	☐ Fluid Restrictions ☐ Encourage Fluids							
☐ Remind Patients to Take Medications								
TIDY:	☐ Living Area ☐ Bathroom ☐ Kitchen							
	☐ Bedroom ☐ Change Linen ☐ Make Bed							
PATIENT'S LAUNDRY:	☐ Wash / Dry / Fold							
☐ Trash Removal								
☐ Shopping								
☐ Social Activities								
ACCOMPANY PATIENT TO:	☐ MD ☐ Other							
✶✶✶✶✶✶ **ADDITIONAL TASKS** ✶✶✶✶✶✶								
ROM:	☐ Active ☐ Passive							
VITAL SIGNS:	☐ Temperature ☐ Pulse							
	☐ Respiration ☐ Blood Pressure							
RECORD:	☐ Intake ☐ Output							
☐ Ostomy Care								

SUPERVISOR NOTIFIED (Name, Date):

DAY	DATE	TIME IN	TIME OUT	TOTAL TIME	CAREGIVER SIGNATURE	PATIENT SIGNATURE
SATURDAY	/ /					
SUNDAY	/ /					
MONDAY	/ /					
TUESDAY	/ /					
WEDNESDAY	/ /					
THURSDAY	/ /					
FRIDAY	/ /					

By my signature I certify that I have been oriented to this patient's plan od care. I have reviewed the Aide Care Plan for any changes or updates and that is client received the services checked above. The information documented here is true and correct.

THE REASON WHY EVV IS MISSING: _____

_____ **Patient's Signature:** _____