



AIDE TIME AND ACTIVITY REPORT

PATIENT: *Patient's first and last name*

Week Ending: 5/14/2016

EMPLOYEE: *Employee's first and last name*

Social Security No: XXX-XX-XXXX

	DATE	TIME IN	TIME OUT	HOURS	EMPLOYEE SIGNATURE	CLIENT/REPRESENTATIVE SIGNATURE
Sun	05/08/2016	10 am	10 pm	12	Employee signature	Patient signature
Mon	05/09/2016	9 am	2 pm	5	Employee signature	Patient signature
Tue	05/10/2016	9 am	2 pm	5	Employee signature	Patient signature
Wed	05/11/2016	9 am	2 pm	5	Employee signature	Patient signature
Th	05/12/2016	9 am	2 pm	5	Employee signature	Patient signature
Fri	05/13/2016	9 am	2 pm	5	Employee signature	Patient signature
Sat	05/14/2016	10 am	10 pm	12	Employee signature	Patient signature
			Total	49		

TASK / ACTIVITY	Sun	M	T	W	Th	F	Sat
PERSONAL CARE: <input type="checkbox"/> Bed <input type="checkbox"/> Tub <input type="checkbox"/> Shower							
<input type="checkbox"/> Hair Care <input type="checkbox"/> Shampoo <input type="checkbox"/> Comb/Brush							
<input type="checkbox"/> Shave <input type="checkbox"/> Nail care (DO NOT CUT NAILS)							
<input type="checkbox"/> Oral Hygiene/Mouth Care <input type="checkbox"/> Denture Care							
<input type="checkbox"/> Skin Care: <input type="checkbox"/> Lotion <input type="checkbox"/> Other							
<input type="checkbox"/> Foot Care							
<input type="checkbox"/> Dressing: <input type="checkbox"/> Total <input type="checkbox"/> Assist							
<input type="checkbox"/> Meals DBF <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Snack							
<input type="checkbox"/> Assist/Feed Patient							
<input type="checkbox"/> Ambulation <input type="checkbox"/> Assist <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> W/C							
<input type="checkbox"/> Transfer <input type="checkbox"/> Bed <input type="checkbox"/> Chair							
<input type="checkbox"/> ROM <input type="checkbox"/> Turn Q2hours							
<input type="checkbox"/> Ostomy/Catheter Care							
<input type="checkbox"/> Non-Sterile Dressing (HHA ONLY)							
<input type="checkbox"/> Medications <input type="checkbox"/> Assist <input type="checkbox"/> Remind							
<input type="checkbox"/> Observe/Report Physical/Mental Changes							
<input type="checkbox"/> Record <input type="checkbox"/> Intake <input type="checkbox"/> Output (HHA ONLY)							
<input type="checkbox"/> Record Temperature <input type="checkbox"/> Record Wound (HHA ONLY)							
<input type="checkbox"/> Toileting <input type="checkbox"/> Toilet <input type="checkbox"/> Commode <input type="checkbox"/> Urinal/Bedpan							
<input type="checkbox"/> Incontinent <input type="checkbox"/> Briefs <input type="checkbox"/> Diapers							
<input type="checkbox"/> Bladder Training <input type="checkbox"/> owel Training							
<input type="checkbox"/> Exercise Program: (PT Inst.) (HHA ONLY)							
HOUSEHOLD							
<input type="checkbox"/> Light Dusting <input type="checkbox"/> Light Vacuuming <input type="checkbox"/> Wet Mop							
<input type="checkbox"/> Bathroom <input type="checkbox"/> Patient Area							
<input type="checkbox"/> Kitchen <input type="checkbox"/> Clean Stove <input type="checkbox"/> Clean Refrigerator							
<input type="checkbox"/> Linen Change <input type="checkbox"/> Laundry							
<input type="checkbox"/> Shopping/Errands <input type="checkbox"/> Escort to Appointments							

EXAMPLE