Helping Hand
HEALTHCARE SERVICES

HOME HEALTH CARE — Aide Activity Note

Patient/ Client Name: _____

	SAT	SUN	MON	TUE	WED	THU	FRI
DATE:							
TIME IN:							
TIME OUT:							
CLIENT/PATIENT INITIALS:							
NUTRITION							
Prepare Meals							
Serve Meals							
Offer Fluids							
Assist with Eating							
TRANSFERRING							
Wheelchair							
Chair							
Bedrest							
Other							
DRESSING							
Self							
Assist							
Other							
PERSONAL CARE							
Tub Bath/ Shower							
Partial / Complete Bed Bath							
Oral Hygiene							
Shampoo							
Skin Care / Grooming							
Shaving							
TOILETING							
Toilet							
Bedside Commode							
Bedpan / Urinal							
Empty Cath Drainage Bag							
Empty Ostomy Appliance							
Diapers/Depends							
AMBULATION							
Ambulation							
Device							
Assist							
Walker							
OTHER							
Medication Reminder							

DATE	CAREGIVER COMMENTS

Caregiver Signature: _____ Print Name: _____

Patient/Designee: I certify that the employee listed on this time slip worked the times indicated and the work was perfect in a satisfactory manner. I agree to the times recording this time slip.

Patient/Client Signature: _____ Print Name: _____