AIDE VISIT RECORD

Date_____ Time In_____ Time Out_____

❑ Q5001: Hospice or Home Health Care provided in patient's home/residence ❑ Q5009: Hospice or Home Health Care provided in place not otherwise specified
❑ Q5002: Hospice or Home Health Care provided in Assisted Living Facility

Check each activity completed during visit, refer to Aide Care Plan.

	ACTIVITIES	REFUSED	COMMENTS
VITALS/RESULTS	T_____ P_____		
	R_____ B/P_____		
	Weight_____ Pain rating_____		
BATH	Tub/Shower		
	Bed Bath - Partial/Complete		
	Assist Bath - Chair		
	Other (specify):		
HYGIENE/GROOMING	Personal Care		
	Assist with Dressing		
	Hair Care		
	Shampoo		
	Skin Care		
	Foot Care		
	Check Pressure Areas		
	Nail Care		
	Oral Care		
	Clean Dentures		
	Other (specify):		
PROCEDURES	Assist with Elimination		
	Catheter Care		
	Ostomy Care		
	Record Intake/Output		
	Inspect/Reinforce Dressing		
	Medication Reminder		
	Other (specify):		

	ACTIVITIES	REFUSED	COMMENTS
ACTIVITY	Assist with Ambulation W/C / Walker / Cane		
	Assist with Mobility Chair / Bed / Dangle / Commode Shower / Tub		
	ROM Active / Passive Arm R / L Leg R / L		
	Positioning - Encourage Assist every _____ hrs		
	Exercise - Per PT/OT/SLP Care Plan		
	Other (specify):		
NUTRITION	Meal Preparation		
	Assist with Feeding		
	Limit/Encourage Fluids		
	Grocery Shopping		
	Other (specify):		
OTHER	Wash Clothes		
	Light Housekeeping Bedroom / Bathroom / Kitchen Change Bed Linen		
	Equipment Care		
	Other (specify):		

Comments/Notes:

Coordination of Care With: ❑ SN ❑ Therapy ❑ Family & Patient

SIGNATURE/DATE

Employee_____ ___/___/___ **Patient**_____ ___/___/___
Date Date

PATIENT NAME - Last, First, Middle Initial | ID#