WellsBrooke
PREMIUM HOME HEALTH CARE®

Weekly Client Care Notes

Flowsheets Used
☐ Urinary ☐ I and O
☐ Bowel ☐ Blood sugar
☐ Vital signs ☐ Weight
☐ Turn and reposition

Use nearest quarter hour in decimal form: 15 min = 0.25; 30 min = 0.5; 45 min = 0.75

Client Name (print):

Employee Name (print):

Date (m/d/yy)	Day	Time In (hh:mm)	Time Out (hh:mm)	Total Hrs. (hh.mm)	Client Signature (Client must sign daily)	Employee Signature (Employee must sign daily)
	Sun					
	Mon					
	Tue					
	Wed					
	Thu					
	Fri					
	Sat					
	Total Hours:				**Employee Signature:**	

To the Employee: Execution of this time sheet is your responsibility. You WILL NOT be paid if signatures or other info are incomplete.

I hereby certify that the information on this time sheet is true.

Procedure: Record the date and exact times of arrival and departure (above). Review the Client Care Plan and check the appropriate shaded areas (below) to indicate care ordered. Include the day of the month beneath each day header and specify level of care given and completion in columns below according to the following key: T=Total; A=Assist; S=Self; D=Decline.

	Care Plan	Su	M	Tu	W	Th	F	Sa
Personal Hygiene								
Oral hygiene	☐							
Denture care	☐							
Complete bed bath	☐							
Partial sponge	☐							
Shower or tub	☐							
Hair: shampoo/comb	☐							
Nail care	☐							
Skin care	☐							
Ted/Jobst hose	☐							
Skin assessment	☐							
Shave: razor /elec.	☐							
Foot care	☐							
Dressing	☐							
Elimination								
Incontinence care	☐							
Use of briefs	☐							
Indwelling catheter care	☐							
Bedside commode	☐							
Bedpan	☐							
Toilet	☐							
Ostomy care	☐							
Intermit. catheterization	☐							
Bowel program	☐							
	☐							

	Care Plan	Su	M	Tu	W	Th	F	Sa
Activity								
Turn/position freq.	☐							
Transfer	☐							
Range of motion	☐							
Assistive device	☐							
Ambulation	☐							
Home Exercise (HEP)	☐							
Home Support, Nutrition, etc.								
Prepare meals	☐							
Feeding	☐							
Feeding tube	☐							
Clean kitchen	☐							
Clean bathroom	☐							
Clean client area	☐							
Make/change bed	☐							
Laundry	☐							
Grocery shopping	☐							
Errands	☐							
Intake/output	☐							
Safety/fall risk	☐							
Neb. treatments	☐							
Med reminder	☐							
Blood sugar remin.	☐							
Vital signs	☐							
Weight	☐							

Other info:

Change in Client Status: Skin ☐ Mental status ☐ General strength ☐ ER visit ☐ **Employee Signature:**

RN supervisor/office notified? Yes ☐ No ☐ **Date** (m/d/yy): **Time** (hh:mm):