Individual ______________________________
Date ______________ Time In ______________ Time Out _____________

AIDE VISIT RECORD

Check each activity completed during visit, refer to Service 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 ___ hours		
		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 □ Physical Therapist □ Occupational Therapist □ Speech Therapist

SIGNATURE/DATE

Provider _________________________________ ___/___/___ **Individual** ____________________________________ ___/___/___
Date Date

Provider Number ____________________________