HARBOR HOME HEALTHCARE, LLC
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PROVIDER AIDE RECORD

(Personal/Respite Care)

Individual's Name:	Phone:

DAY:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
DATE (Month/Day/Year):	/ /	/ /	/ /	/ /	/ /	/ /	/ /
ACTIVITY:							
Complete/Partial Bath							
Dress/Undress							
Assist with Toileting							
Transferring							
Personal Grooming							
Assist with Eating/Feeding							
Ambulation							
Turn/Change Position							
Vital Signs							
Assist with Self-Admin. Medication							
Bowel/Bladder							
Wound Care							
ROM							
Supervision							
Prepare Breakfast							
Prepare Lunch							
Prepare Dinner							
Clean Kitchen/Wash Dishes							
Make/Change Bed Linen							
Clean Areas Used by Individual							
Listing Supplies/Shopping							
Individual's Laundry							
Medical Appointments							
Work/School/Social							
Other							
DAILY TIME IN							
DAILY TIME OUT							
NUMBER OF HOURS							

Weekly Comments or Observations (required):

Answer each question by checking the box that applies	Y	N	Observation if YES
1. Did you observe any change in the individual's physical condition?			
2. Did you observe any change in the individual's emotional condition?			
3. Was there any change in the individual's regular daily activities?			
4. Do you have an observation about the individual's response to services rendered?			

Additional Comments/Observations (if needed):

Use back of page if more room needed for additional comments or observations

Weekly Signatures:

Individual's/Family's Signature Date	Print Aide's Name
RN's Signature (not mandatory) Date	Aide's Signature Date:

This form contains patient-identifiable information and is intended for review and use of no one except authorized parties. Misuse or disclosure of this information is prohibited by State and Federal Laws. If you have obtained this form by mistake, please send it to: DMAS, 600 East Broad Street, Suite 1300, Richmond, VA 23219

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