



CERTIFIED HOME HEALTH AIDE NOTES

PATIENT NAME: _____

VISIT DATE: _____

HOME HEALTH AIDE'S NAME: _____

VISIT TIME IN: _____

HH AIDE'S SIGNATURE: _____

VISIT TIME OUT: _____

Completed	Description
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Completed	Description
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Completed	Description
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Bathing:

- Complete Bed Bath
- Sponge Bath
- Tub bath with bench
- Tub bath without bench
- Shower with bench
- Shower without bench
- Peri Care

Dressing:

- Independent
- Needs Help

Activities:

- Ambulation with walker
- Ambulation with cane
- Ambulation with wheelchair
- Bed Bound
- Wheelchair Bound
- Repositioned
- Transfer chair
- Transfer bed
- Transfer commode
- Other: _____

Nutrition:

- _____
- _____
- Requires assist with feeding
- Other: _____

Skin Care:

- Applied lotion
- Back rub
- Reported Signs of pressure/breakdown
- Other: _____
- Reported change in condition to nurse

Shave:

- Shave

Hair Care:

- Bed Shampoo
- Tub Shampoo
- Sink Shampoo
- Set Hair
- Comb Hair

Oral Hygiene:

- Brush Teeth
- Clean Dentures
- Other: _____

Nail Care:

- Clean Nails
- File Nails
- DIABETIC: Do not cut or file nails

Foot Care:

- Soak Feet (lukewarm water only)
- DIABETIC: Do not cut or file nails

Light Housekeeping:

- Change Linens
- Tidy patient area after care.
- Other: _____

Vital Signs:

Blood Pressure Rate: _____

Pulse Rate: _____

Respiratory Rate: _____

Temperature: _____

Blood Sugar Rate: _____

Comments:
