

**GREATER BOSTON**  
HOME HEALTH CARE SERVICES, INC.

Office Use

Month / Day / Year  
Week Ending Friday

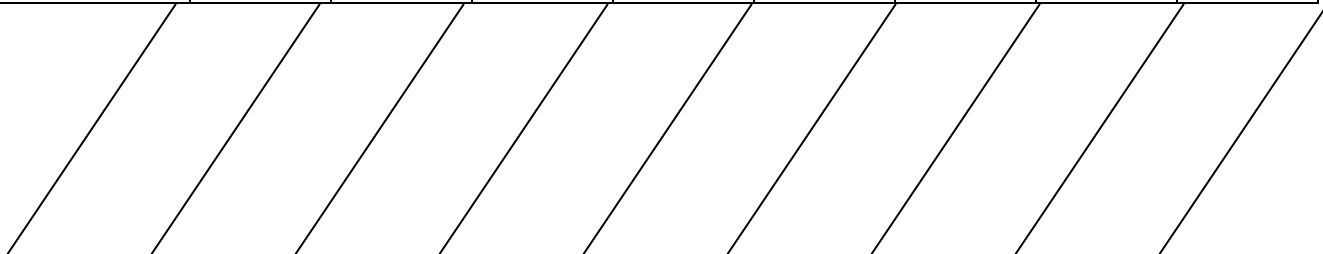
PATIENT: \_\_\_\_\_ CASE #: \_\_\_\_\_ EMP # \_\_\_\_\_  
Last Name First Name

ADDRESS: \_\_\_\_\_

	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
VISIT DATE:							
TIME ARRIVED:							
TIME LEFT:							
TOTAL HOURS:							

ENTER (X) FOR EACH ACTIVITY PERFORMED

<b>PERSONAL CARE</b>								
Bath (Specify Type)								
Mouth Care								
Special Skin Care								
Turning Patient								
Foot Care								
Hair: Shampooing								
Shaving								
Assist with Dressing								
Assist with Eating								
Assist with Walking								
Assist with Toileting								
Assist with Transfers								
Medication Reminder								
Temp/Pulse/Respiration								
Blood Pressure								
Weight								
Urinalysis								
Bed making								
Use of Equipment								
Other:								
<b>ACTIVITIES WITH PATIENT</b>								
Assist with Exercise								
Walk Out of Doors								
Recreation								
Accompany Patient to:								
Help Patient Relearn Household Routine								
<b>FOOD &amp; HOUSEHOLD</b>								
Special Diet/Restrictions								
Food/Planning/Preparation								
Food/Shopping/Dishwashing								
Laundry								
Care of Patient Room								
Housework (Specify)								
Other (Specify)								
Supervision of HHA								
HHA Signature								



Patient Signature