

# HOME HEALTH AIDE CHARTING SHEET

Norwell Visiting Nurse  
Association, Inc.

PATIENT'S NAME \_\_\_\_\_

EMPLOYEE'S SIGNATURE \_\_\_\_\_

W/E DATE \_\_\_\_\_

PATIENT'S NUMBER	MONDAY	EMPLOYEE NUMBER	TUESDAY	PATIENT NAME	WEDNESDAY	EMPLOYEE NAME	THURSDAY	FRIDAY	SATURDAY	SUNDAY	WEEK'S TOTAL HOURS	MILEAGE TOTAL
	VISIT DATE		TUESDAY		THURSDAY		FRIDAY	SATURDAY	SUNDAY	TOTAL TIME	Mileage	

PERSONAL CARE	MON	TUES	WED	THURS	FRI	SAT	SUN
BATH: <input type="checkbox"/> TUB <input type="checkbox"/> SHOWER							
BED BATH <input type="checkbox"/> PART <input type="checkbox"/> COMP							
SHAVE: <input type="checkbox"/> FACE <input type="checkbox"/> AXILLA <input type="checkbox"/> LEG <input type="checkbox"/> COMB <input type="checkbox"/> SHAMPOO							
ROUTINE MOUTH CARE							
DENTURE CARE							
FOOT CARE							
ROUTINE SKIN CARE							
SPECIAL SKIN CARE: SPECIFY							
DRESSING: <input type="checkbox"/> ASSIST <input type="checkbox"/> SELF							
TEMP/PULSE/RESP. & RECORD							
WEIGH PATIEN & RECORD							
REMIND PATIENT TO TAKE MED.							
RECORD INTAKE/OUTPUT							
SIMPLE DRESSING CHANGE							
OSTOMY <input type="checkbox"/> ASSIST WITH APPL <input type="checkbox"/> CLEANSING							
DECUBITI CARE							
CATHETER CARE: <input type="checkbox"/> CLEANSING <input type="checkbox"/> CARE OF DRAINAGE UNIT <input type="checkbox"/> SITZ BATH <input type="checkbox"/> PERINEAL FLUSH							
EMOTIONAL SUPPORT							
UNIVERSAL PRECAUTIONS							
ELIMINATION <input type="checkbox"/> BED PAN <input type="checkbox"/> URINAL							
B. S. COMMUNE							
BATHROOM							
OTHER:							
MOBILITY TRANSFERS ASSIST WITH AMBULATION <input type="checkbox"/> CANE <input type="checkbox"/> CRUTCHES <input type="checkbox"/> WALKER							
TRANSFER BED/CHAIR <input type="checkbox"/> WHEELCHAIR <input type="checkbox"/> HOYER LIFT							
POSITION/TURN PATIENT							
EXERCISES SPECIFY OTHER							
SAFETY							
SEIZURE PRECAUTIONS							
O PRECAUTIONS							
CLEAN EQUIPMENT							
DIETARY PREPARE MEAL: AM NOON PM SNACK							
PLAN MENU							
FEED PATIENT							
OFFER FLUIDS							
OTHER							
HOUSEKEEPING GROCERY SHOP CHANGE LINEN LIGHT HOUSEKEEPING WASH CLOTHES/LAUNDRY							
OTHER:							
RN/PT NOTIFIED DATE _____ OF: _____							
RN /PT / HHA COMMNETS: _____							

CALL THE OFFICE IF THE PATIENT  
HAS 1) A FALL 2) INCREASE IN TEMP  
3) SKIN BREAKDOWN 4) NO BM X 3  
DAYS 5) IF THERE IS ANY QUESTIN  
OR PROBLEM.