PACIFIC HOME HEALTH CARE
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ANT 10/10

AIDE VISIT RECORD

Patient Name (Last, First, M.I.):	*ID#:*	*Date of Visit:*	*Time In:*	*Time Out:*

Check each activity completed during visit, refer to Aide Care Plan

		ACTIVITIES	REFUSED	COMMENTS
VITALS/ RESULTS		T_____ P_____		
		R_____ B/P_____		
		Weight_____ Pain Rating_____		
BATH		Tub / Shower		
		Bed Bath - Parital / 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		Asist 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 ____ hrs		
		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 ☐ PT ☐ OT ☐ ST

Patient's Signature:	*Date:*	*Employee's Print Name & Signature:*	*Date:*