

A & D VISITING NOTE

PATIENT NAME: _____ EMPLOYEE NAME: _____
 BRANCH _____

OFFICE USE ONLY

DAY	MARE	ATTN	HKM	PA	CHOICE	PVT	INSU	RES	VA	SSBG	T3	T3E	VHSP
MON													
TUES													
WED													
THUR													
FRI													
SAT													
SUN													

DAY	DATE	TIME IN	TIME OUT	TOTAL HOURS	TYPE1	TYPE2	TYPE3	PT INITIAL	STAFF INITIAL
MON									
TUES									
WED									
THUR									
FRI									
SAT									
SUN									

TYPES: ATTN/HMK/CHOICE/PA/RES/MEDICARE/T3/T3E/SSBG/CHSP/INSUR WEEKLY HOURS: _____

DESCRIPTION	M	T	W	TH	F	SA	SU	DESCRIPTION	M	T	W	TH	F	SA	SU
TUB/SHOWER ASSIST								REPOSITION BED/CHAIR PATIENT							
BATHROOM CLEAN UP								MEDICATION REMINDERS							
PERINEAL CARE								ASSIST TO BR, BSC, BED PAN							
SKIN CARE/LOTION								CATH CARE, FOLEY/EXT							
ORAL CARE/SHAVE								INCONTINENT CARE							
SHAMPOO/COMB								PREP OF MEALS/SNACKS							
SAFETY PROCAUTIONS								ERRANDS							
NAILS CLEAN/FILE								KITCEN CLEAN UP							
DRESS/UNDRESS								BED MADE/ LINEN CHANGE							
ASSIST WITH AMBULATION								CLIENT LAUNDRY DONE							
RANGE OF MOTION								MAINT. CLEAN EQUIP							
TRANSFER ASSIST								VACCUM/DUSTING							
			A			&					O			N	
							D								L
															Y
MECHANICAL LIFT								OSTOMY CARE							
OTHER								RECORD INTAKE/OUTPUT							
ASSIST FEEDING								CHECK/ REINFORCE DRESSING							

EMPLOYEE SIGNATURE: _____ DATE _____

PATIENT SIGNATURE _____ DATE _____