Best Home Care, Inc

Home Health Aide Activity Sheet

201-798-7600 *CHHA Employee ID#*_____

CLIENT NAME (Print Clearly)	CLIENT ADDRESS (Print Clearly)	CHHA NAME (Print Clearly)
CLIENT SIGNATURE		**CHHA SIGNATURE**
I, the above signed guarantee the fact that the signing Best Home Care, Inc. employee has worked the hours shown below. The activities marked were performed satisfactory on the days indicated.		*I, certify that the hours shown below represent my total hours worked and they were properly confirmed by the client or an authorized representative.*

○ Group	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Date							
Live-In or Nights	○	○	○	○	○	○	○
Time In							
Time Out							
Total Hours							

√-CHHA Performed R- Client Refused

Daily Activities	Sun	Mon	Tue	Wed	Thu	Fri	Sat
1.Positioning: A. Up as tolerated B. T & P every 2 hours							
2. Bathing: A. Shower B: Sponge C. Bed Bath D. Chair							
3. Hair Care: A. Shampoo B. Shower C. Bed D. Groom							
4. Mouth Care: A. Denture Care B. Brush Teeth C. Rinse mouth							
5. Skin Care: A. Lotion B. Nail/ foot care-do not cut C. Shave (electric)							
6. Dressing: A. Assist B. Complete C. Day D. Evening							
7. Ambulation: A. Walking (guard while ambulatory) B. Cane C. Walker D. Wheelchair							
8. ROM: A. Active B. Passive C. Elevate lower extremities							
9. Transfer: A. Bed to Chair B. Hoyer lift C. Pivot							
10. Diet: A. Fluids B. Encourage C. Restrict D. Regular E. Low Salt F. Low Fat G. Diabetic H. Other							
11. Meal Prep: A. Breakfast B. Lunch C. Dinner D. Feed E. Cut F. Supervise							
12. Medications: A. Remind Medications							
13. Elimination: A. Toilet B. Commode C. Bed Pan D. Measure I/O E. Catheter F. Incontinent Care							
14. Light Housekeeping: A. Bedroom B. Bathroom C. Kitchen							
15. A. Linen Change B. Laundry							
16. A. Make Bed							
17. A. Shopping							
18. Other Duties:							

Week Ending Date:
must be a Saturday

Sheet Reviewed By:

Any Change in Patient Status: Contact RN Immediately
Date_____ Time of Call_____

Report given to RN, Supervisor:_____

See back for comment ☐

Discrepancy ☐☐ **NO** ☐☐ **YES**

Referred to Nurse_____

Date_____

WE WILL NOT ACCEPT ACTIVITY SHEETS WITH CORRECTIONS, INCOMPLETE, INCORRECT, OR NOT SIGNED.

Location:	*Location*	*Location*	*Location*
879 Bergen Avenue Suit 200.	*448 Main St. Ste#1*	*5506 Bergenline Ave.2nd Fl.*	*333 N Broad Street Ste # 2A*
Jersey City NJ 07306	*Fort Lee NJ 07024*	*West New York NJ 07093*	*Elizabeth NJ 07208*
Tel: 201-798-7600	*Tel: 201-920-6477*	*Tel: 201-766-9500*	*Tel: 732-203-5700*
Fax: 201-798-7601	*Fax: 201-322-0288*	*Fax: 201-766-9502*	*Fax: 908-344-6134*