

# CARE PROVIDER SERVICES CLIENT CARE LOG

**Client Name:** \_\_\_\_\_ **Care Provider Name:** \_\_\_\_\_

**Role**  CNA/  HHA  Companion **Week Ending Date:** \_\_\_\_\_

*Pursuant to Regulations by the Agency for Health Care Administration, it is mandatory that Care Provider document any changes in care services.*

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<b>DATE:</b>							
<b>HOURLY/ VISIT START TIME:</b>							
<b>HOURLY/VISIT END TIME:</b>							
<b>TOTAL HOURS:</b>							
<b>LIVE-IN START DATE:</b>							
<b>LIVE-IN END DATE:</b>							
<b>WORKED HOURS:</b>							
<b>DAILY CLIENT REVIEW &amp; APPROVAL (CLIENT INITIALS)</b>							

*As per the direction of Client, the Care Provider performed the following services:*

### COMPANIONSHIP/ HOMEMAKER

IADL SUPERVISION / STANDBY ASSIST							
ACCOMPANY TO APPOINTMENTS							
GROCERY SHOPPING							
PREPARE MEALS							
CHANGE BED LINEN							
LAUNDRY							
LIGHT HOUSEKEEPING							
COSMETIC ASSISTANCE							
REPORTED INCIDENTS OR CLIENT BEHAVIORAL CHANGES							

### PERSONAL CARE /ADL ASSISTANCE

<b>BATHING/SHOWER</b>							
<b>DRESSING</b>							
<b>AMBULATION</b>							
<b>TRANSFERRING</b>							
RE-POSITIONING							
<b>FEEDING</b>							
GROOMING, SHAVING, HAIR CARE							
APPLY LOTION							
ORAL HYGIENE							
<b>TOILETING</b>							
<b>INCONTINENCE CARE</b>							
ASSIST WITH PRESCRIBED RANGE OF MOTION							
ASSIST WITH PRESCRIBED ICE CAP OR COLLAR							
SIMPLE URINE TEST							
MEASURE INTAKE / OUTPUT							
RECORD VITAL SIGNS							
RECORD WEIGHT							
MEDICATION REMINDERS							

### OTHER CNA/ HHA TASKS: REQUIRES ADDITIONAL CLIENT CONSENT & MEDICATION LIST ON FILE

ASSISTANCE WITH SELF- ADMINISTRATION OF MEDS							
ASSIST WITH USE OF GLUCOMETER MACHINE							
ASSIST WITH ANTI-EMBOLISM STOCKINGS							
ASSIST WITH APPLYING &/ OR REMOVING OXYGEN CANNULA							
ASSIST WITH USE OF CPAP/ BIPAP DEVICE ONLY							
MEASURED VITAL SIGNS							
ASSIST WITH COLOSTOMY BAG CHANGES							

By signing below, I (Client) contracted with Care Provider for whom I consent and certify that all services noted above within the approved dates and times were performed. I understand that if services were not performed as requested, I would not sign this care log. Care logs submitted without the checking of Activities of Daily Living actually performed, and required by the insurance company, may result in the patient/client being billed directly.

**Signed by Client:** \_\_\_\_\_

By signing below, I (Care Provider) certify that this Care Log represents the actual care services requested by Client and provided by me as the Independent Care Provider for the dates listed above.

**Signed by Care Provider:** \_\_\_\_\_