**SENIOR SERVICES PLUS HEALTH CARE, INC. PERSONAL CARE WORKER WEEKLY RECORD OF CARE**

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ PCW SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_

(MY SIGNATURE INDICATES THE INFORMATION PROVIDED IS CORRECT)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| TRAVEL TO CLIENT: circle one  from: home = H client = C office =O | | | | | | CLIENT SCHEDULE  (based on allowed time) | | | | | TRAVEL FROM  CLIENT: (circle, same codes) | | | | | | OFFICE USE ONLY: | |
|  | Date | | **FROM:** | **TIME LEFT** | | **SHIFT IN:** | | **SHIFT OUT:** | | | **TIME LEFT** | | **TIME END** | | **TO:** | | **TRAVEL TIME** | **HRS WORKED** |
| Sun | |  | H O C |  | |  | |  | | |  | |  | | H O C | |  |  |
| Mon | |  | H O C |  | |  | |  | | |  | |  | | H O C | |  |  |
| Tues | |  | H O C |  | |  | |  | | |  | |  | | H O C | |  |  |
| Wed | |  | H O C |  | |  | |  | | |  | |  | | H O C | |  |  |
| Thurs | |  | H O C |  | |  | |  | | |  | |  | | H O C | |  |  |
| Fri | |  | H O C |  | |  | |  | | |  | |  | | H O C | |  |  |
| Sat | |  | H O C |  | |  | |  | | |  | |  | | H O C | |  |  |
| **TOTALS:** | | | | | | | | | | | | | | | | |  |  |
| **CONSULT PLAN OF CARE (POC**  CIRCLE PLACE Xs BY WHAT YOU DID | | | | | **SUN** | | **MON** | | **TUES** | **WED** | | **THURS** | | **FRI** | | **SAT** | **COMMENTS:**  **(ANY CHANGES TO POC)** | |
| Bathing: bed bath tub sponge | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Shower: bench/bars standby assist | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Hair Care: shampoo set comb style | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Oral Care: teeth dentures | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Skin Care: lotion Rx  breakdown call RN | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Nail Care | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Dressing/Undressing | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Grooming | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Apply Remove: splints braces teds | | | | |  | |  | |  |  | |  | |  | |  |  | |
| ROM/Exercise | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Eye Glasses/Hearing Aid Care | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Catheter Care | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Transfers | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Toileting (indicate # of times-- Xs) | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Bowel Program | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Vital Signs | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Medication Reminders | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Wound Care | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Medical Appointments | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Ambulation | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Falls Prevention | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Hand-feed meals | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Reposition | | | | |  | |  | |  |  | |  | |  | |  |  | |
|  | | | | |  | |  | |  |  | |  | |  | |  |  | |
| **HOUSEKEEPING:** | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Meal Preparation/Serve | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Bed (Change/make) | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Light Cleaning | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Laundry | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Food Shopping | | | | |  | |  | |  |  | |  | |  | |  |  | |
| Other: | | | | |  | |  | |  |  | |  | |  | |  |  | |
| **Client Signature: Date Signed:**  12/19/2013 (Through my signature I confirm that the information above is accurate) | | | | | | | | | | | | | | | | | | |