**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 onefrom: 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)  |