Kris Agency & Home Care Inc.

Record of Service /Timecard

169-14 Hillside Avenue, Jamaica, NY 11432
Tel: 718-262-9009 Fax: 718-262-8213

CLIENT NAME: _____ **EMPLOYEE NAME:** _____
(PRINT) **First** **Last** (PRINT) **First** **Last**

ADDRESS: _____ **SSN (last 4 digits):** _____

Day	Date (mm/dd/yy)	Time Started	Time Finished	Total Hours	Client's Signature (MUST SIGN DAILY)	Employee's Signature (MUST SIGN DAILY)
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						

Check off duties performed daily	**M**	**T**	**W**	**TH**	**F**	**S**	**S**	**Check off duties performed daily**	**M**	**T**	**W**	**TH**	**F**	**S**	**S**
100 Bath-Tub								306 Range of Motion Exercises							
101 Bath-Shower								311 Turning and positioning (At least Q2)							
102 Bath-Bed								400 Take Temperature							
103 Patient requires Total Care								403 Take Pulse							
106 Mouth Care/Denture Care								404 Take respirations							
107 Hair Care-Comb								411 Remind to take medication							
108 Hair Care-Shampoo								500 Change bed linen							
109 Grooming-Shave								501 Patient Laundry							
110 Grooming-Nails								502 Light Housekeeping							
111 Dressing								505 Clean Patient Care Equipment							
112 Skin Care								506 Do Patient shopping and errands							
113 Foot Care								508 Accompany Patient to medical appointment							
114 Toileting-Diaper								509 Diversional Activities-Speak/Read							
115 Toileting-Commode								511 Monitor Patient Safety							
116 Toileting-Bedpan/Urinal								**HHA DUTIES**							
117 Toileting-Toilet								**406 Weigh Patient**							
201 Patient is on a prescribed diet								**407 Record Output (Urine/BM)**							
202 Prepare-Breakfast								**408 Assist with catheter care**							
203 Prepare-Lunch								**409 Empty Foley bag**							
204 Prepare-Dinner								**410 Assist with ostomy care**							
205 Prepare Snack								**412 Assist with Treatment / Finger stick**							
206 Assist with feeding								**PLEASE NOTE:**							
207 Record intake – Food															
208 Record intake - Fluid															
300 Transferring															
301 Assist with walking															
302 Patient walks with assistive devices															
305 Assist with home exercise program															

1. **USE BLACK INK ONLY**
2. Fill this form every day that you work with the client.
3. You and the client must sign daily.
4. **IN CASE OF A PATIENT EMERGENCY, CALL 911 AND THEN NOTIFY THE AGENCY AT 718-262-9009**
5. **ANY CHANGES IN THE CLIENT MUST BE REPORT TO THE AGENCY IMMEDIATELY. PLEASE CALL 718-262-9009.**
6. **MAIL, FAX OR BRING TIMESHEET(S) TO THE AGENCY EVERY MONDAY BEFORE 12 NOON**

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COMMENT(S):

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