

Senior Care Companion

Phone or Fax # 214-469-2092

Client Name: _____

Client Signature: _____

Document those tasks listed on the ISP.
Use a check mark to indicate task performed.
Use an "R" to indicate the client or family refused.
Notify Supervisor of any condition changes.

You are responsible for reading the Individualized Service Plan daily.

Documentation must be submitted weekly.

	SUN	MON	TUE	WED	THURS	FRI	SAT
DATE							
TIME IN							
TIME OUT							
TOTAL HOURS							
CLIENT INITIALS							

Activities Ordered (✓ all that apply)

Bath: <input type="checkbox"/> Bed <input type="checkbox"/> Shower <input type="checkbox"/> Tub							
Hair: <input type="checkbox"/> Shampoo <input type="checkbox"/> Comb/Brush							
<input type="checkbox"/> Oral hygiene/care							
<input type="checkbox"/> Assist with ambulation							
<input type="checkbox"/> Assist with medications							
<input type="checkbox"/> Transfers							
<input type="checkbox"/> Use of assistive devices							
Type:							
<input type="checkbox"/> Meal Preparation							
Diet:							
<input type="checkbox"/> Assist with feeding							
<input type="checkbox"/> Assistance with company/visitors							
<input type="checkbox"/> Transportaion							
Linens: <input type="checkbox"/> Change <input type="checkbox"/> Wash <input type="checkbox"/> Make Bed							
<input type="checkbox"/> Clean Bathroom							
<input type="checkbox"/> Dust							
Floors: <input type="checkbox"/> Vacuum <input type="checkbox"/> Sweep <input type="checkbox"/> Mop							
<input type="checkbox"/> Shopping/Errands							
<input type="checkbox"/> Other							
<input type="checkbox"/> Universal Precautions/ Safety Measures							

Employee signature below certifies all information is true and correct and no injuries were sustained during assignment.

Employee Name: _____

Employee Signature: _____