HOME CARE VISIT REPORT

NAME OF CLIENT: **LOCATION:**

CAREGIVER ON DUTY: **DATE:** **TIME IN:** **TIME OUT:**

CAREGIVER ARRIVAL

☐	Expected the visit
☐	Forgot about visit
☐	Receptive to visit
☐	Unreceptive to visit

ACTIVITIES & OUTINGS

DESCRIPTION	Transport	MI/KM	Reimbursement
	☐		
	☐		
	☐		

MOOD

☐	Good	☐	OK	☐	Not Good

FOOD LOG

MEAL	TIME	DESCRIPTION
Breakfast		
Lunch		
Snack		
Supper		
ANY CHANGES:		

ENERGY LEVEL

☐	High	☐	Medium	☐	Low

SHARPNESS OF MIND

1 Low – 10 High	1 2 3 4 5 6 7 8 9 10

HYDRATION / LIQUID INTAKE

PERSONAL CARE

☐

☐

☐

HOUSEKEEPING TASKS COMPLETED

☐

☐

☐

MEDICATIONS & VITAMIN SUPPLEMENTS

Medicine/Vitamin	TIME TAKEN	DOSAGE

OBSERVATIONS

☐ Mobility Changes

☐ Refusal to take medication(s)

☐ Environment Safety Issues

☐ Fluid Intake Adequate

☐ Bruising or Sore Visible

☐ Urine Output Adequate

Circle - Constipated/Regular/Loose BM

NOTES:

VITALS:	TEMP		PL		RR		BP	

MEDICAL APPOINTMENT(S)

TIME	NAME OF PHYSICIAN /THERAPIST	TYPE	REASON

APPOINTMENT

TIME	DESCRIPTION	LOCATION

Supplies Needed

☐

☐

☐

☐

TOILETING [U=Urination BM=Bowel Movement]

TIME	U	BM	Independent	With Assistance	Change Brief
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

NOTES

X

SIGNATURE OF CAREGIVER ☐ **Family** ☐**Private** ☐**Agency**