Hendlee Home Care

In-Home Aide Timesheet

Caregiver Name _____

Patient Name _____

Month/Year _____

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Date							
Time In							
Time Out							
Time In							
Time Out							
Ttl Hrs Worked							

BATHING	**Sun**	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**GROOMING**	**Sun**	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**
Shower/Tub Bath								Haircare/shampoo							
Sponge/Bed bath								Skin care feet/face/hand							
Upper body								mouth/denture care							
Lower body								Nail care							
Bath transfer								Assist w/shaving							
DEVICES/EQUIPMENT	**Sun**	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**DRESSING**	**Sun**	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**
Assist with TEDS								Fastening clothes							
Assist with Braces/Splints								Shoes/Clothes on							
Assist with Binders								Shoes/Clothes off							
Assist with Prosthetics								Hang/retrieve clothes							
Retrieve/Return Equipment															
MOBILITY	**Sun**	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**NUTRITION**	**Sun**	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**
Ambulate room to room								Heat/serve food							
Transfer to/from bed								Cutting food							
Transfer to/from chair								Open food packages							
Clear pathway of clutter								Assist w/feeding							
Assist with Stairs								G-Tube feeding/care							
ROM								Equipment setup							
Turn reposition															
TOILETING	**Sun**	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**HOUSEKEEPING**	**Sun**	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**
Assist with toileting								Laundry on-site tasks							
Transfer to/from toilet								Change linen							
Hygiene after toileting								Clean/Tidy Bedroom							
Catheter care								Make Bed							
Empty bedpan/urinal/BSC								Clean/Tidy Bathroom							
Ostomy Care								Clean kitchen							
Garment aide /Assist								Clean dishes/utensils							
Incontinence Care/change								Empty Trash/dispose							
								Sweep/Mop/Vacuum							
OTHER ASSISTANCE	**Sun**	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**DELEGATED MONITORING**	**Sun**	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**
Wellness check								Pulse/Respirations							
Errands/Transportation								Blood Pressure							
Companionship								Glucose Monitoring							
								Medication Reminders							

Service Codes:

✓ **= Complete** **R = Refused** **N = Not done**

Notes/Deviations: (make additional notes on back if more space is needed)

_____

_____

Caregiver Signature

Date

Client/Responsible Party Signature

Date

Revised 10.02.22