AIDE DUTY SHEET

Please check one: ☐PCA ☐HHA ☐PA

ameristar home care

PATIENT'S NAME: FIRST: _____ LAST: _____

PATIENT'S STREET ADDRESS: _____

CITY: _____ STATE: **NY** ZIP CODE: _____

	SUN	MON	TUES	WED	THUR	FRI	SAT
DATE							
START TIME							
END TIME							
TOTAL HOURS DAILY							
Check duties completed each day:	✔	✔	✔	✔	✔	✔	✔
BATH: ☐CHAIR ☐SHOWER ☐TUB							
SHAMPOO/HAIR CARE							
SPECIAL SKIN CARE							
MOUTH CARE							
DRESSING							
TOILETING							
WALKING: ☐INDOORS ☐OUTDOORS							
TRANSFERRING							
ASSIST WITH EXERCISE							
REINFORCE DRESSING							
REMIND TO TAKE MEDICATIONS							
WEIGH PATIENT							
EMPTY COLOSTOMY BAG							
EMPTY CATHETER BAG							
TEST URINE							
TAKE: ☐PULSE ☐RESP. ☐TEMP.							
TURN AND POSITION							
ASSIST WITH FEEDING							
PREPARE MEAL: ☐B ☐L ☐D ☐S							
CHANGE/MAKE PATIENT BED							
LIGHT HOUSEKEEPING							
LAUNDRY							
CLEAN KITCHEN/WASH DISHES							
CLEAN BATHROOM AFTER PATIENT USE							
MARKETING/ERRANDS							
CLEAN PATIENT'S BEDROOM							
PLAN OF CARE PRESENT IN HOME							
HANDWASHING (INFECTION CONTROL)							
USE FACE MASK (DURING FLU SEASON)							
ESCORTING TO MEDICAL APPOINTMENT							
MONITOR PATIENT SAFETY							

		SUN	MON	TUES	WED	THUR	FRI	SAT
SUN	PATIENT SIGNATURE	CAREGIVER SIGNATURE	CAREGIVER SIGNATURE	CAREGIVER SIGNATURE	CAREGIVER SIGNATURE	CAREGIVER SIGNATURE	CAREGIVER SIGNATURE	CAREGIVER SIGNATURE
MON	PATIENT SIGNATURE							
TUES	PATIENT SIGNATURE							
WED	PATIENT SIGNATURE							
THUR	PATIENT SIGNATURE							
FRI	PATIENT SIGNATURE							
SAT	PATIENT SIGNATURE							

CAREGIVER'S NAME: FIRST: _____ LAST: _____