TRI-MED

Serving Brooklyn, Queens, Manhattan, Bronx, Staten Island, Nassau and Suffolk

PH: (347) 727-7200 *...caring for generations* FAX: (347) 727-7217

DAILY TIME SHEET

Name: _____ Week Ending:_____/_____/_____

Patient's Name: _____ Social Security: _____/_____/_____

Date	Day	Time In	Time Out	Hours	Employee Signature	Client /Family Signature	Supervisor's Signature
	Sun						
	Mon						
	Tues						
	Wed						
	Thur						
	Fri						
	Sat						

Total Hours for the week: **NO SERVICES WILL BE PAID WHEN CLIENT IS HOSPITALIZED. ONLY AUTHORIZED HOURS WILL BE PAID.**

TASK	Sun	M	Tue	W	Thu	Fri	Sat
BATH: ❑Tub 100 ❑Shower 101 ❑Bed 102 PATIENT REQUIRES TOTAL CARE: ❑103							
MOUTH CARE: ❑106 HAIR CARE: ❑Comb 107 ❑Shampoo 108 ❑Foot Care 113							
GROOMING ❑Shave 109 ❑Nails 110 DRESSING ❑ 111 ❑ Skin Care 112							
TOILETING ❑ Diaper 114 ❑ Commode 115 ❑ Bedpan 116 ❑ Toilet 117							
PREPARE ❑ Diet 201 ❑ Breakfast 202 ❑ Lunch 203 ❑ Dinner 204 ❑ Snack 205							
ASSIST WITH FEEDING : ❑ 206 RECORD INTAKE: ❑ Food 207 ❑ Fluid 208							
TRANSFERRING: ❑ 300 ASSIST: ❑ Walking 301 ❑ W/ Devices 302 ❑ Home Exercise 305							
RANGE OF MOTION EXERCISES ❑ 306 TURNING AND POSITIONING ❑ 311							
TAKE: ❑Temperature 400 ❑Pulse 403 ❑Blood Pressure 405 WEIGH PATIENT ❑ 406							
REMIND PATIENT TO TAKE MEDICATION ❑ 411 ASSIST WITH TREATMENT ❑ 412							
ASSIST: ❑Catheter Care 408 ❑Foley bag 409 ❑Ostomy Care 410 SAFETY: ❑511							
TAKE RESPIRATIONS ❑ 506 RECORD OUTPUT (URINE/BM) ❑ 307							
CHANGE PATIENT'S LINEN: ❑ 500 LAUNDRY: ❑ 501 LIGHT HOUSEKEEPING ❑ 502							
CLEAN PATIENT CARE EQUIPMENT ❑ 505 ACCOMPANY PATIENT TO DOCTOR ❑ 508							
SHOPPING/ERRANDS ❑ 506 DIVERSIONAL ACTIVITIES-SPEAK/READ ❑ 509							

FOR LIVE-IN PATIENTS ONLY WEEK STARTING: _____ TO WEEK ENDING: _____

1. 5 Hours Uninterrupted Sleep: Yes ☐ No ☐
   If no, please specify: _____
2. 3 Hours Additional Sleep: Yes ☐ No ☐
   If no, please specify: _____
3. 3 Hours Uninterrupted Meal Time: Yes ☐ No ☐
   If no, please specify: _____

By signing below, I further acknowledge that I had 5 hours of uninterrupted sleep with 3 additional hours of sleep and 3 hours of uninterrupted meal time. I also acknowledge that I have adequate sleeping arrangement in the patient home. I understand that if I do not get my uninterrupted time to sleep, I will immediately inform my agency at livein@trimedhomecare.com
I certify that this form is true and accurate.

Caregiver's Signature: _____ **Date:** _____

REMINDER: IN ORDER FOR PAYROLL TO PROCESS YOUR PAYMENT, TIMESHEET MUST BE COMPLETED IN FULL AND SENT OVER TO OUR OFFICE BY NOON ON MONDAYS.

TRI-MED HOME CARE SERVICES, INC. & TRI-MED STAFFING, INC.

Caregiver's Signature: _____ **Date:** _____