



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

FOR LIVE-IN PATIENTS ONLY

WEEK STARTING: _____ TO WEEK ENDING: _____

- 5 Hours Uninterrupted Sleep: Yes No
If no, please specify: _____
- 3 Hours Additional Sleep: Yes No
If no, please specify: _____
- 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: _____