# HOME HEALTH AIDE TIMESHEET

**CLIENT NAME (First, M, Last)**  
**HOME HEALTH AIDE (First, M, Last)**

For the week of: **Sunday MM/DD/YY**  
**MM/DD/YY**  
**MM/DD/YY**  
**MM/DD/YY**  
**MM/DD/YY**  
**MM/DD/YY**

### DATES OF SERVICE (MM/DD)

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### TOTAL HOURS FOR WEEK

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### BATH

- Bath/Shower
- Sponge Bath/Bed Bath
- Shampoo
- Shave
- Oral Care/Denture Care
- Dressing

### BLADDER/ BOWEL

- Catheter Care
- Toilet/Commode
- Bedpan/Urinal
- Brief/Pad
- Incident

### AMBULATION

- Distance
- Frequency
- Assist with Transfers
- Use Transfer Belt
- Bedbound
- Weight Bearing: Full/Partial
- Cane/Crutches
- Walker/Wheelchair

### RANGE OF MOTION

- PROM
- AROM
- U L
- Apply Limb Prosthesis
- Braces
- TEDS/Aoe Wraps

### SKIN / SENSORY

- Lotion to Skin
- Nail Care
- Turn & Position
- Foot Soak
- Non Sterile Dress Chg
- Glasses/Contacts
- Hearing Aide: L R
- Restrict Fluids/Push Fluids
- Feed Client
- Meal Prep: B L D SN
- Supplement Given
- Weight

### MEALS

- Vacuum
- Laundry
- Kitchen/Dishes
- Bathroom(s)
- Empty Garbage
- Make Bed, Change Linen

### COMMENTS:

(Changes in client condition must be documented and RN Supervisor notified.)

### CLIENT SIGNATURE  
**DATE**  
**HOME HEALTH AIDE SIGNATURE**  
**DATE**

**NOTE:** ALL TIMESHEETS MUST BE RECEIVED EVERY MONDAY BY 10:00AM FOLLOWING THE WEEK WORKED.  
PLEASE CALL AFTER YOU SEND YOUR TIMESHEETS TO MAKE SURE THEY WERE RECEIVED.  
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