

Client #: \_\_\_\_\_ Service Goals/Objectives: \_\_\_\_\_

Client #: \_\_\_\_\_

N Assignment/Aide Log for Client: \_\_\_\_\_

Special Instructions/Findings/Safety Measures (check below) **Diagnosis:**  
 hospital bed  manual W/C  electric W/C  shower bench/chair  bath safety bars  
 det. shower head **Client uses:**  bedside commode  elevated toilet seat  bedpan  urinal  pads  
**Client is/has:**  SOB  tracheostomy  vent  oxygen continuous  oxygen rate: \_\_\_\_\_  
 oxygen intermittent  nebulizer treatments  generalized weakness  high risk for falls  
 pain where: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  
 requires step by step verbal prompting  not alert and oriented  behavior problems  
 forgetful  hearing problems  speech problems  DNR order copy in home

**RN Assignment to Aide/RN Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

|   | Sun | Mon | Tues | Wed | Thur | Fri | Sat |
|---|-----|-----|------|-----|------|-----|-----|
| #19 Mobility/Activity Restrictions ambulate client with <input type="checkbox"/> cane <input type="checkbox"/> quad cane <input type="checkbox"/> walker Day(s) of Wk: S M T W Th F Sat             |     |     |      |     |      |     |     |
| or <input type="checkbox"/> bed/chair bound - whenever you get client up transfer with <input type="checkbox"/> hooyer <input type="checkbox"/> transfer board <input type="checkbox"/> trapeze bar |     |     |      |     |      |     |     |
| <input type="checkbox"/> use pressure relief device <input type="checkbox"/> turn and position  |     |     |      |     |      |     |     |
| #20 Eating <input type="checkbox"/> feed client <input type="checkbox"/> oral <input type="checkbox"/> parenteral <input type="checkbox"/> tube diet: _____ supplements: _____                      |     |     |      |     |      |     |     |
| <input type="checkbox"/> chop <input type="checkbox"/> grind <input type="checkbox"/> puree <input type="checkbox"/> thicken diet restrictions: _____   |     |     |      |     |      |     |     |
| #27 Meal Prep meal prep <input type="checkbox"/> 1 meal <input type="checkbox"/> 2 meals <input type="checkbox"/> set-up only   |     |     |      |     |      |     |     |
| <input type="checkbox"/> take out trash <input type="checkbox"/> wash dishes & tidy <input type="checkbox"/> clean kitchen <input type="checkbox"/> other: specify _____                            |     |     |      |     |      |     |     |
| #21 Bathing <input type="checkbox"/> full body bath   |     |     |      |     |      |     |     |
| <input type="checkbox"/> partial bath   |     |     |      |     |      |     |     |
| <input type="checkbox"/> shower   |     |     |      |     |      |     |     |
| <input type="checkbox"/> sponge bath  |     |     |      |     |      |     |     |
| <input type="checkbox"/> shampoo hair   |     |     |      |     |      |     |     |
| <input type="checkbox"/> foot care <input type="checkbox"/> special skin care   |     |     |      |     |      |     |     |
| #8 Bathroom <input type="checkbox"/> tidy after bath <input type="checkbox"/> clean bathroom - what days: _____   |     |     |      |     |      |     |     |
| <input type="checkbox"/> 2 Dressing <input type="checkbox"/> retrieve clothes <input type="checkbox"/> put clothes on and take clothes off  |     |     |      |     |      |     |     |
| <input type="checkbox"/> don/remove therap. stockings <input type="checkbox"/> don/remove prosthesis  |     |     |      |     |      |     |     |
| <input type="checkbox"/> assist with buttons, fasteners, zippers <input type="checkbox"/> stockings/socks/shoes on/off  |     |     |      |     |      |     |     |
| #5 Personal Hygiene <input type="checkbox"/> comb hair <input type="checkbox"/> brush teeth <input type="checkbox"/> clean dentures   |     |     |      |     |      |     |     |
| <input type="checkbox"/> wash/dry face and hands <input type="checkbox"/> oral care   |     |     |      |     |      |     |     |
| <input type="checkbox"/> oraid or set hair <input type="checkbox"/> shave   |     |     |      |     |      |     |     |
| #23 Toileting - Assist with: <input type="checkbox"/> toileting bladder <input type="checkbox"/> toileting bowel <input type="checkbox"/> ostomy care Day(s) of Wk: S M T W Th F Sat                |     |     |      |     |      |     |     |
| <input type="checkbox"/> indwelling catheter care <input type="checkbox"/> condom catheter care <input type="checkbox"/> I/O cath care  |     |     |      |     |      |     |     |
| <input type="checkbox"/> clean perineum <input type="checkbox"/> change client  |     |     |      |     |      |     |     |
| <b>Client has:</b> <input type="checkbox"/> constipation <input type="checkbox"/> administer enema (specify type)   |     |     |      |     |      |     |     |
| #24 Contenance: Assist with: <input type="checkbox"/> bowel/toileting program   |     |     |      |     |      |     |     |
| client uses: <input type="checkbox"/> diapers <input type="checkbox"/> disposable underwear   |     |     |      |     |      |     |     |
| #26 Delegated Medical Monitoring <input type="checkbox"/> ROM   |     |     |      |     |      |     |     |
| <input type="checkbox"/> Blood Pressure Notify RN when: _____   |     |     |      |     |      |     |     |
| <input type="checkbox"/> Blood Sugar Notify RN when: _____  |     |     |      |     |      |     |     |
| <input type="checkbox"/> med assist <input type="checkbox"/> med reminders <input type="checkbox"/> other _____   |     |     |      |     |      |     |     |
| #29 Bedroom/Living Area <input type="checkbox"/> make bed <input type="checkbox"/> keep free of clutter <input type="checkbox"/> tidy   |     |     |      |     |      |     |     |
| <input type="checkbox"/> sweep  |     |     |      |     |      |     |     |
| <input type="checkbox"/> dust   |     |     |      |     |      |     |     |
| #30 General <input type="checkbox"/> laundry <input type="checkbox"/> change bed linens <input type="checkbox"/> check smoke alarm  |     |     |      |     |      |     |     |
| <input type="checkbox"/> mop <input type="checkbox"/> vacuum  |     |     |      |     |      |     |     |
| #31 Errands/Misc. <input type="checkbox"/> grocery shop <input type="checkbox"/> pay utility bill   |     |     |      |     |      |     |     |
| <input type="checkbox"/> pick up med/medical supplies <input type="checkbox"/> reading/writing/reporting  |     |     |      |     |      |     |     |

Aide checks off under the days of week when task(s) completed. If the Client refuses a task, alert the RN.

Aide/Date: Sun. \_\_\_\_\_ / Mon. \_\_\_\_\_ / Tues. \_\_\_\_\_ /  
 Wed. \_\_\_\_\_ / Thurs. \_\_\_\_\_ / Fri. \_\_\_\_\_ / Sat. \_\_\_\_\_ /  
 Client/Fam. \_\_\_\_\_ Date: \_\_\_\_\_ RN reviewed: \_\_\_\_\_ Date: \_\_\_\_\_