Reset Form

AIDE WEEKLY ACTIVITY LOG

Mango Home Health
Commitment to excellence

Office Address : 190 State Route 27, Suite 301-302, Edison, NJ 08820

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www.mangohomehealth.com, Fax: 732 505 0083

Time Sheet
Week Ending Date
Must be a Sat.
MONTH DAY YEAR

____/____/____

Client Last Name, First Name (PRINT NEATLY)

Client Address :

Employee Last Name, First Name (PRINT NEATLY)

Client ID Number :

Employee ID Number :

Clock ID

Clock Phone : 866-979-3461

	SUN	MON	TUES	WED	THURS	FRI	SAT
DATE	12 / 23 / 25	/ /	/ /	/ /	/ /	/ /	/ /
Live - In	| |	| |	| |	| |	| |	| |	| |
Time In							
Time Out							
Total Daily Hrs							

Employee (chha) Signature

Client Signature

My signature certifies that I provided services to the client on the dates and times listed above. I understand that I will be paid bases on the verified time on this time slip and that my pay includes compensation for time spent providing client care, documentation, and travel between cases. I did not receive any injuries during this assignment.

I, the above signee, confirm and verify the worked the dates and hours shown above.

DAILY ACTIVITIES :	SUN	MON	TUE	WED	THU	FRI	SAT
Standard Precautions Used							
Client Status : Alert / Confused / Forgetful / Non-Responsive							
Ambulatson : Independent / with Assist / Pivot / Bed Bound / Turn & Position							
DME/Mobility : Independent / Cane / Walker / Wheelchair / Contact Guard							
Supervison / Cratches / Braces / Hoyer lift / Prosthesis							
Personal Care :							
Bathing : Shower / Sponge / Bed Bath / Chair / Supervise							
Hair Case : Shampoo / Shower / Bed / Groom							
Orel Case : Dentures Care / Brush Teeth / Rinse / Self / Assist							
Skin Care : Lotion / Nail-Footcare (Do not cut nails) /Shave (Electric only)							
Dressing : Assist / Total Care							
Elimination : Toilet / Commode / Bedpan / Urinal / Catheter							
Urine : Continent / Incontinent / Catheter							
Bowels : Continent / Incontinent / Colostomy							
Diet : Regular / Low Salt / No Salt / Diabetc / Renal / Chopped / Pureed / G-Tube							
Meal Prep : Breakfast / Lunch / Dinner / Snack							
Feeding : Self / Assist / Feed Client							
Fluid Entake : Encourage / Restrict							
Light Housekeeping : Clinet's Area							
Tidy Bedroom / Bath / Kitchen							
Dust / Vaccuum / Mop Floor							
Make Bed							
Linen Change							
Laundry							
Social Care :							
Encourage Walks / Read Books / Play Cards / Conversations							
Vital Signs as Directed by RN							
BP / Heart Rate / Temperature / Weight							
Shopping / Essands							
Safety Supervision : Safe Home/Unsafe							
(Report Safety concerns with RN Promptly)							
Other :							

Report any change in client's condition to : Agency RNs#732-505-0080

Date : _____ Time of Call _____ Name of RN _____

Report Given to RN _____

(Use reverse side for additional notes)

Sheet Reviewed by / date

Discrepancy ☐ **No** ☐ **Yes**

RN

Signature : _____

Date :