HOSPICE AIDE VISIT RECORD

Date_____ **Time In**_____ **Time Out**_____

Check each activity completed during visit, refer to Aide Care Plan.

	ACTIVITIES	REFUSED	COMMENTS
VITALS/ RESULTS	T_____ P_____		
	R_____ B/P_____		
	Weight_____ Pain rating_____		
BATH	❑ Tub ❑ Shower		
	Bed Bath ❑ Partial ❑ Complete		
	Assist Bath - Chair		
	Other (specify):		
HYGIENE/GROOMING	Personal Care		
	Assist with Dressing		
	Hair Care		
	Shampoo		
	Skin Care		
	Moisturizer		
	Foot Care		
	Check Pressure Areas		
	Nail Care		
	Oral Care		
	Clean Dentures		
	Shave		
	Other (specify):		
PROCEDURES	Perineal Care		
	Assist with Elimination		
	Catheter Care		
	Ostomy Care		
	Record ❑ Intake ❑ Output		
	Inspect/Reinforce Dressing		
	Medication Reminder		
	Other (specify):		

	ACTIVITIES	REFUSED	COMMENTS
ACTIVITY	Assist with Ambulation ❑ W/C ❑ Walker ❑ Cane		
	Assist with Mobility ❑ Chair ❑ Bed ❑ Dangle ❑ Commode ❑ Shower ❑ Tub		
	Gait Belt at All Times		
	ROM ❑ Active ❑ Passive ❑ Arm ❑ R ❑ L ❑ Leg ❑ R ❑ L		
	❑ Reposition ❑ Encourage Position Change Every ____ Hrs		
	Exercise - Per ❑ PT ❑ OT ❑ SLP Care Plan		
	Other (specify):		
NUTRITION	Meal Preparation		
	Assist with Feeding		
	❑ Limit ❑ Encourage Fluids		
	Grocery Shopping		
	Elevate Head of Bed After Meal		
	Other (specify):		
OTHER	Wash Clothes		
	Light Housekeeping ❑ Bedroom ❑ Bathroom ❑ Kitchen ❑ Change Bed Linen		
	Equipment Care		
	Other (specify):		

Comments/Notes: _____

Coordination of Care With: ❑ SN ❑ Therapy ❑ PT ❑ OT ❑ SLP ❑ Family ❑ Patient

SIGNATURE/DATE

Employee_____ _____ *Date* **Patient**_____ _____ *Date*

PATIENT NAME - Last, First, Middle Initial	ID#