Angels ON DUTY INC.

PATIENT'S LAST NAME, FIRST NAME

VISIT REPORT

Medication Reminder	Breakfast	Lunch	Dinner	Bedtime
Check when given				
Meals Prepared	**Breakfast**	**Lunch**	**Dinner**	**Snack**
What was prepared?				
Appetite	**Percentage Eaten:**	**Percentage Eaten:**	**Percentage Eaten:**	**N/A**

Daily Housekeeping: **Circle or write in Completed chores**

Laundry	Vacuum/Sweep/Mop	Pet Care
Bathroom	Dust	Additional
Kitchen	Dishwasher	

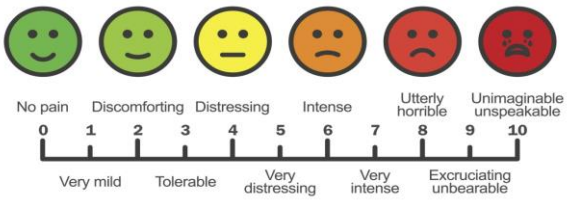
History Of Falls or Safety Concerns	**Yes or No** **Report Fall to Supervisor.**
Alert and Oriented	**(Circle which applies)** **1. Person** **2. Place** **3. Time**
Memory Impaired/Cognitive Impaired/ Confused?	**Yes or No**
Functionally Impaired/Physically Impaired	**Yes or No**

ACTIVITES OF DAILY LIVING

(Must have 2 out of 6 activities checked per visit)

Assisted with:	CHECKBOX	NOTES
1) Bathing/Hygiene		
2) Continence		PADS /CHUX BRIEFS DEPENDS (CIRCLE ONE)
3) Dressing/Personal Care (Hair, Skin, Oral)		
4) Eating (Feeding)		
5) Toileting		BM_____ EMPTY CATHETER BAG_____ EMPTY URINAL _____
6) Transferring		Assistive Devices: (Circle all that apply) Standby Assist Gait Belt Walker Wheelchair Lift

Pain Level: Report unrelieved pain to Supervisor



NOTES

TREATMENTS: **O2 SAT:** **BREATHING TX:** **WT:** **BLOOD SUGAR:** **SKIN RX:** **OTHER:**

TRANSPORTATION: DRIVE PATIENT IN THEIR CAR			ERRAND MILES (EMPLOYEE CAR):		I certify that all information on this visit report is correct.
DATE	DAY OF WEEK	TIME IN	TIME OUT	TOTAL HOURS	CAREGIVER'S NAME (PRINT):
OFFICE USE ONLY					CAREGIVER'S SIGNATURE:
Updated Form 3/7/19					