Angels ON DUTY INC.

Patient's Last Name, First Name

VISIT REPORT

Medication Reminder

Breakfast Lunch Dinner Bedtime

Diet

Good Fair Poor Night Shift

Housekeeping

Daily			**Weekly**	
Laundry	Bathroom	Kitchen	Vacuum /Sweep/Mop	Change BedLinens

Safety/Mood/Affect

	Independent		**Assist**		**Full**	**Notes**
MOBILITY						
TRANSFERS						
PERSONAL CARE (Oral Care, Skin Care, Hair brush)						
SHOWER/BATH						
TOILETING						
NUTRITION						BM_____
PAIN	No Pain		Moderate		Unbearable Pain	Report unacceptable pain level to supervisor.

VITAL SIGNS	T	P	R	B/P	O2SAT-	WEIGHT	TIME	BLOOD SUGAR-

DATE	**DAY OF THE WEEK**	**TIME IN**	**TIME OUT**	**TOTAL**	**EMPLOYEE SIGNATURE**

PAYROLL CODE	**BILLING CODE**