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: Check or write in completed chores

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

History Of Falls or Safety Concerns	Yes No Report Fall to Supervisor.
Alert and Oriented	(Check which applies) 1. Person 2. Place 3. Time
Memory Impaired/Cognitive Impaired/ Confused?	Yes No
Functionally Impaired/Physically Impaired	Yes 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 ((Check One)
3) Dressing/Personal Care (Hair, Skin, Oral)		
4) Eating (Feeding)		
5) Toileting		BM___________ EMPTY CATHETER BAG__________ EMPTY URINAL ___________
6) Transferring		Assistive Devices: (Check all that apply) Standby Assist Gait Belt Walker Wheelchair Lift

Pain Level: Report unrelieved pain to Supervisor	NOTES
No pain 0, 1 Very mild, Discomforting 2, 3 Tolerable, Distressing 4, 5 Very distressing, Intense 6, 7 Very intense, Utterly horrible 8, 9 Excruciating unbearable, Unimaginable unspeakable 10	

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					