WEEKLY SERVICE REPORT

Patient Name ____________________ __________ Date ____________________ County

Place a check in the box for each day a task is performed. Write an N in each box assigned but Not needed that day.

HOMEMAKER																COMPANION							
Days of the Week	S	M	T	W	T	F	S	Days of the Week	S	M	T	W	T	F	S	Days of the Week	S	M	T	W	T	F	S
Vacuum/Sweep/Mop								Make Bed								Assist/Supervise with							
Clean Oven/Stove								Tidy Living Area								Meal Plan/Prepare							
Defrost/Clean Refrig								Remove Trash								Laundry							
Change/Wash Linen								Purchase Groceries								Grocery Shopping							
Wash/Mend/Iron								Obtain Prescriptions								Essential HM Chores							
Wash Dishes								Remind to take Meds								Patient Bath							
Sanitize Bathroom								Write/Mail Letters								Grooming/Hygiene							
Assist Paying Bills								Assist with Phone								Remind to take Meds							
Plan/Fix/Serve Meal								Orient to Day Events								Go to Medical Visits							
Encourage Diet								See/Tell Condition															
Dust								**Total Service Time**								**Total Service Time**							

PERSONAL CARE																UNSKILLED RESPITE							
Bathe Patient								Plan/Fix/Serve Meal								Personal Care							
Skin/Hair/Oral Care								Essential HM Chores								Homemaker							
Dress Patient								Bowel/Bladder								Supervise/Support							
Turn Patient								Remind to take Meds															
In/Out of Bed								Monitor Condition															
Feed Patient																							
Walk Patient								**Total Service Time**								**Total Service Time**							

COMMENTS:

This is to certify that the information on this form is true, accurate and complete. I understand that I am certifying that I have received the services listed on the dates specified. (List services provided in services box below as: HM = homemaker, PC = personal care, CO = companion, UR = unskilled respite)

	Date	Time-In	Time-Out	Services	Patient Signature	Worker Signature
S						
M						
T						
W						
T						
F						
S						

Reviewed by Supervisor & Date ____________________

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