Prosper Home Care Service Record Form

Client Name:_____ Period Start Date: ___/___/_____ M/D/Y

Employee Name:_____ Period End Date: ___/___/_____ M/D/Y

Black ink only! Do not use white out! Must be neat and legible or will not be accepted. No scribble. No military time, Am/Pm Only.

RN Supervisor Use Only:

I have reviewed this SRF and verify that it corresponds to the care plan. Any discrepancies have been discussed with the employee and/or client.

❑Notification sent to PCP

_____ ___/___/_____ M/D/Y

RN/LPN Signature ***Date Signed***

	SU	M	TU	W	TH	F	SA
Date							
Time In	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Total Hrs							
Client Int							
Employee Int							

All service record forms must be signed with date and initialed by both client and employee to be accepted.

VITALS (Enter Values, not checkmarks. Circle values reported to RN)	SU	M	TU	W	TH	F	SA
Blood Pressure Report values less than 90/50, more than 180/100, out of client's normal							
Temperature Report values more than 38.0C/101F or less than 35.0C/96F							
Respirations Count 1 full minute, Report values less than 12 or more than 25							
Pulse Count 1 full minute, report values less than 50 or more than 100							
Blood Glucose (Report Values less than 50 or more than 350)							
Weight (Report value change of +/- 5 pounds in one week)							
BM Date Circle date if more than 3 days and reported to supervisor							

PERSONAL CARE (Checkmarks)	SU	M	TU	W	TH	F	SA
Bathing - Write **T**-Tub, **S**-Shower, **B**-Bed bath, **SP**-Sponge Bath							
Assist with Dressing - Monitor for balance and safety							
Assist with Toileting - Cueing & perineal cleaning, changing diaper							
Assist with Grooming and Shampooing Hair							
Nail Care - Filing Fingernails Only, Never cut nails or file toenails							
Assist with Oral Hygiene, Clean dentures							
Special Needs - (Write **BP** for bowel program, **CC** for catheter care including emptying bag, **PS** for peg site cleaning)							

AMBULATION AND MOBILITY (Checkmarks)	SU	M	TU	W	TH	F	SA
Assist In/Out of Bed, Chair, Wheelchair							
Assist with Walking - Monitor for safety							
Repositioning every two hours							
Encourage and Cue Physical activity or use of DME							
Encourage and Cue range of motion exercises							
Place Phone or ERS in client's reach before leaving							
Report any falls or injuries on or off shift, notate details on back							

Client: By signing below, I confirm that this service record form is complete and accurate to the best of my knowledge. I confirm that the employee worked the hours as listed and completed the tasks as marked.

OFFICE USE ONLY: Date Received Stamp

_____ ___/___/_____ M/D/Y

Client Signature ***Date Signed***

Service record forms are due every Tuesday by 5pm immediately following last service date for this week.

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NUTRITION (Checkmarks)	SU	M	TU	W	TH	F	SA
Keep fluids within client's reach during shift and before leaving							
Prepare meals and clean dishes							
Encourage and educate on balanced and diagnosis specific meals							
Assist with eating - hand feeding or tube feeding (never put meds in tube)							
Observe/Report meal accumulation and food storage							
Observe/Report cooking equipment failure							

MEDICATIONS / MEDICALLY RELATED TASKS (checkmarks)	SU	M	TU	W	TH	F	SA
Remind/Assist with medications - Never choose medication or fill pill box							
Pharmacy - pick up or drop off prescriptions							
Report medication errors, missed meds or new meds (Report to Supervisor)							
Provide watchful supervision and oversight							
Applying basic first aid in case of minor injury, report to supervisor							
Utilizing universal precautions							
Documenting client's intake and output as requested							
Observing/Reporting changes in client's condition							

HOUSEKEEPING (Client areas only, not extended to others in the home, client is responsible for providing all cleaning products and	SU	M	TU	W	TH	F	SA
Laundry - wash/dry/fold/put away							
Vacuum, sweep, mop, dust							
Remove trash daily							
Clean kitchen, microwave, fridge, stove top, oven (wipe down only)							
Clean bathroom, sink, toilet, tub, countertop, floor							
Change linens, make bed							
Assist with household shopping once a week (only client allowed in vehicle)							

COGNITIVE STIMULATION / HOUSEHOLD MANAGEMENT (checkmarks)	SU	M	TU	W	TH	F	SA
Encourage puzzles, crafts, participation in social activities							
Assist with bill paying, assistance and Medicaid applications							
Reading, writing, and interpreting books or other documents							
Schedule medical appointments, accompany as needed (client only)							
Providing caregiver relief, companion sitter services							
Encourage conversation and mental stimulation							

COMMUNICATION	YES/NO	If YES, note date and give details.
Did client have or report any falls or injuries?		
Did client have any bruising, wounds, or skin tears?		
Did employee note any signs of abuse or neglect?		
Has the condition of the client changed this week?		
Did client have any dr's appts or visit urgent care?		
Did the client go to the ER?		

Service Synopsis - Please write a brief summary of how services went this week and detail any incidents or changes.

Employee Initials _____

Employee: By signing below, I certify that the information contained in this service record form is accurate and subject to verification before receiving pay for these services. I also acknowledge that I have not received any injury nor has my client received any injury in the performance of my duties.

_____ ___/___/_____ M/D/Y

Employee Signature ***Date signed***

Prosper Home Care
3088 Mercer University Drive Suite 100
Atlanta, GA 30341

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