ADL Must have Client's name and Caregiver's name to be processed for payroll.

AGENCY: EXCEL HEALTH CARE SERVICES **Patient's Last Name:** ______________________ **First Name:** ______________________		**Print Name:** **Print Name:** **Print Name:**			Week Starting ____/____/____ Week Ending ____/____/____	
Check service performed on each visit. DO NOT do anything that is not on the patient's care plan without Agency permission **DATE →**							
Bath: ☐ Bed ☐ Shower ☐ Tub							
Shampoo/Hair Care							
Mouth Care							
Dress							
Shave							
Special Skin Care ☐ **INTACT** ☐ **IRRITATION**							
Nail Care if not diabetic ☐ Fingers ☐ Toes							
Transfer Activity							
Change Position							
Range of Motion (R.O.M.)							
Walking							
Up with Help							
Foot Care							
Encourage Fluids							
Feeding							
Incontinence Care							
Empty Catheter Bag							
Assist with Commode, Urinal, Bedpan, or Toilet							
Reinforce Non sterile Dressing							
Take Vital Signs (record at right)							
Empty Ostomy Equipment							
Prepare & Serve Meal/Snack							
Laundry							
Clean Client's Bathroom							
Change/Make Bed							
Clean Kitchen							
Wash Dishes							
Grocery Shopping/Run Errands							
Ironing							
Clean Client's Bedroom/ Vacuum							
Maintain Safety							
Diversional Activities/Socialization							
I certify that I have performed the activities noted above, honored the patient's rights, and utilized the Universal Precaution							
Time In →							
Time Out →							
Total Hours →							
Total Hours For The Week →							
Employee Initial →							
Employee Signature →							
Client's Signature →							

If Skin IRRITATION occurs Please check the following: ☐ **RASH** ☐ **BRUISE** ☐ **OPEN SKIN** ☐ **WOUND**

ADL Must have Client's name and Caregiver's name to be processed for payroll.

AGENCY: EXCEL HEALTH CARE SERVICES **Patient's Last Name:** ___ **First Name:** ___			**Print Name:** **Print Name:** **Print Name:**			Week Starting ____/____/____ Week Ending ____/____/____	
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