Visiting Nursing Association of WNY, Inc.

AIDE ASSIGNMENT SHEET

CLIENT NAME: _____
ADDRESS: _____
_____

CHHA _____ **LTHHC** _____
AIDE NAME _____
LEVEL: HHA PCAII HSKPR

ID# _____ C.T. _____
PHONE: _____

DAYS:
HOURS:

SUN	MON	TUES	WED	THURS	FRI	SAT

SPECIAL OBSERVATIONS & PRECAUTIONS

ALLERGIES:
MEDICAL CONDITIONS
LIMITATIONS: _____
_____
_____

GOAL(S) FOR SERVICE: _____
_____

MEDICATION:
( ) Self-Administered ( ) Aide Reminds
( ) Pre-Poured by Nurse
( ) Family Member Prepares: _____
Name
( ) Pharmacy: _____

IMPORTANT TELEPHONE NUMBERS

EMERGENCY: _____ NO. _____
CASEWORKER: _____ NO. _____
VISITING NURSING ASSOCIATION NO. _____
NURSE: _____ NO. _____
AIDE AGENCY: _____ NO. _____
PHYSICIAN: _____ NO. _____
RELATIVE/FRIEND: _____ NO. _____
RELATIVE/FRIEND: _____ NO. _____
TRANSPORT CO.: _____ NO. _____
TYPE: ( ) Cab ( ) Wheelchair ( ) Ambulance
PCA TO ACCOMPANY TO:

UNIVERSAL PRECAUTIONS MUST BE FOLLOWED BY ALL HEALTH CARE PERSONNEL

DAY	EVE	NITE	CHECK ACTIVITY - SPECIFY FREQUENCY/SPECIAL INSTRUCTION/RESTRICTIONS
PERSONAL CARE			
			Bathing - Assist With: ( ) Bed ( ) Shower ( ) Sink-Sponge ( ) Other:
			Skin Care - Assist With Soaking: ( ) Feet ( ) Hands
			Apply Lotion To:
			Back Care
			Nail Care - Clean And File (NO CUTTING)
			Shave ( ) Self ( ) Assist
			Mouth Care: ( ) Teeth ( ) Dentures ( ) Rinse Mouth
			Hair Care: ( ) Brush/Comb ( ) Shampoo - Frequency:
			Dress: ( ) Self ( ) Assist
			Toileting: ( ) Toilet ( ) Commode ( ) Bedpan/Urinal ( ) Catheter/Tubing
ACTIVITY			
			Bed Rest - Turn And Position Patient
			Walking: ( ) Alone ( ) Assist ( ) Walker ( ) Cane ( ) Wheelchair
			Assist With Transfer: ( ) Pivot ( ) Hoyer Lift ( ) Other:
			Encourage Active Range of Motion (ROM)
			Meals: ( ) Regular ( ) Special:
			Meal Preparation: ( ) Prepare/Serve ( ) Prepare For Later Use By Client ( ) Meals On Wheels
			Special Feeding Instructions
			Assist Client With Bill Paying
			Remind Client To Take Medications
			Weigh
			Record Intake And Output
HOUSEKEEPING			
			Beds: ( ) Make ( ) Change
			Clean/Tidy: ( ) Bedroom ( ) Bathroom ( ) Kitchen ( ) Living Room
			( ) Vacuum/Sweep ( ) Mop ( ) Dust
			Empty Trash
			Clean/Defrost Refrigerator
			Laundry: ( ) Washer ( ) Hand ( ) Laundromat ( ) Iron ( ) Mending
			Grocery Shopping
			Errands - Specify:
			OTHER - Specify:
SPECIALIZED PROCEDURES FOR HHA ONLY			
			Vital Signs: ( ) TPR ( ) AP ( ) BP
			Change/Reinforce Simple Dressing
			*Ostomy Care - Specify:
			*Perform Therapy Program
			*Test Urine
			*OTHER - Specify:

** Perform only if specifically assigned and demonstrated by SN / Rehab Therapist - for this client ONLY!*

COMPLETED BY: _____ DATE: _____