Company Name

AIDE ASSIGNMENT SHEET

Date: _____ Time: _____

Patient: _____ ID#: _____

Care Manager _____ Phone # _____

Frequency/Duration: Aide visits_____ Super. Visits _____

Patient/Client problem: _____

_____

Goals for care: ☐ Effective and safe personal care ☐ Patient/Client clean, comfortable

☐ Other (specify): _____

PARAMETERS TO NOTIFY CARE MANAGER

T _____ BP _____

P _____ R _____

Urine _____

Other (pain) _____

_____

PRECAUTIONARY AND OTHER PERTINENT INFORMATION: *Check all that apply. Circle the appropriate item if separated by slash.*

Patient/Client Address _____ Phone _____

Directions to Home _____

☐ Lives alone
☐ Lives, with other
☐ Alone during the day
☐ Bed Bound
☐ Bed rest ☐ BRPs ☐ Up as tolerated
☐ Amputee (specify):_____
☐ Partial weight bearing: ☐ Right ☐ Left
☐ Non weight bearing: ☐ Right ☐ Left
☐ Hip precautions
☐ Special equipment:_____

☐ Speech/Communication deficit
☐ Vision deficit: ☐ Glasses ☐ Contacts
☐ Other:_____
☐ Hearing deficit: ☐ Hearing Aid
☐ Dentures: ☐ Upper ☐ Lower ☐ Partial
☐ Oriented x 3 ☐ Alert
☐ Forgetful / Confused
☐ Urinary catheter
☐ Prosthesis (specify):_____
☐ Allergies (specify): _____

☐ Diab[illegible] ☐ Do not [illegible]t nails
☐ Diet[illegible] _____
☐ Seizure pre[illegible]tion
☐ [illegible]
☐ Watch f[illegible] hyperglycemia / hypoglycemia
☐ Ble[illegible]g Precautions
☐ [illegible]one to fractures
☐ [illegible]ther (specify):_____
☐ _____
☐ _____

ASSIGNMENT: *Check all applicable tasks. Specify by circling the applicable activity or those items separated by slashes. Write additional precautions, instructions, etc., as needed beside the appropriate items.*

BATH
- ☐ Bath: Tub / Shower (F1)
- ☐ Bed Bath: Partial / Complete (F2)
- ☐ Assist Bath – Chair

HYGIENE/GROOMING
- ☐ Personal Care (F4)
- ☐ Assist with Dressing
- ☐ Hair Care: Brush / Shampoo / Other:
- ☐ Skin Care / Foot Care (Hygiene) Check Pressure Areas
- ☐ Shave / Groom / Deodorar[illegible]
- ☐ Nail Hygiene: Clean / Fi[illegible]
- ☐ Oral Care: Brush / Sw[illegible]
- ☐ Elimination Assist

PROCEDURES
- ☐ Catheter care (F6)
- ☐ Ostomy care
- ☐ Record output
- ☐ Inspect / Reinforce Dressing *(see below)
- ☐ Assist with Medications *(see below)

ACTIVITY
- ☐ Ambulation Assist (F8) WC / Walker / Cane
- ☐ Mobility Assist: Chair / Bed / Dangle / Commode / Shower / Tub
- ☐ ROM: Active / Passive; Arm: R / L; Leg: R / L
- ☐ Positioning: Encourage / Assist to Turn every _____ Hrs.
- ☐ Exercise – Per: PT / OT / SLP Care Plan (F10)

NU[illegible]RITION
- ☐ D[illegible] Order
- ☐ [illegible]ood Allergies:
- ☐ Meal Preparation (F11)
- ☐ Assist with Feeding
- ☐ Fluids: Limit / Encourage
- ☐ Grocery Shopping (F12)

OTHER
- ☐ Wash Clothes (F13)
- ☐ Light Housekeeping (F14): Bedroom / Bathroom / Kitchen / Change Bed Linen
- ☐ Equipment Care
- ☐ Pain Management

VITALS
- ☐ T: O / A / R – Record _____ / week – Report
- ☐ P: Wrist / Pedal, R / L Record _____ / week – Report
- ☐ R: Record _____ / week
- ☐ BP: Record _____ / week
- ☐ Weight: Record _____ / week – Report
- ☐ Pain/Location:
- ☐ Other (specify):

*Wound Care – Inspect/Reinforce Dressing: _____

*Assist with Meds (describe): _____

Special instructions/Safety Measures: _____

INITIAL ASSIGNMENT: Signature/Title: _____ Date:_____ Time:_____

THIS ASSIGNMENT SHEET MUST BE REVIEWED AND/OR REVISED AT LEAST EVERY 60 DAYS.

REVIEWED/REVISED: Signature/Title: _____ Date:_____ Time:_____