# AIDE WEEKLY VISIT RECORD

EMPLOYEE NAME _____

EMPLOYEE NO. _____

**When completing, be sure to follow the Aide Care Plan.**

| | DAY ➡ | SUN | MON | TUE | WED | THU | FRI | SAT | WEEK OF |
|---|---|---|---|---|---|---|---|---|---|
| | DATE | | | | | | | | / / THROUGH / / |
| | TIME IN | | | | | | | | |
| | TIME OUT | | | | | | | | |
| | AIDE'S INITIALS | | | | | | | | |
| | PATIENT'S INITIALS | | | | | | | | |
| | **ACTIVITIES** | **SUN** | **MON** | **TUE** | **WED** | **THU** | **FRI** | **SAT** | **COMMENTS (All comments must be dated.)** |
| VITALS/RESULTS | T_____ P_____ | | | | | | | | |
| | R_____ B/P_____ | | | | | | | | |
| | Wt._____ Pain rating_____ | | | | | | | | |
| BATH | Tub/Shower | | | | | | | | |
| | Bed Bath - Partial/Complete | | | | | | | | |
| | Assist Bath - Chair | | | | | | | | |
| | Other (specify): | | | | | | | | |
| HYGIENE/GROOMING | Personal Care | | | | | | | | |
| | Assist with Dressing | | | | | | | | |
| | Hair Care | | | | | | | | |
| | Shampoo | | | | | | | | |
| | Skin Care | | | | | | | | |
| | Foot Care | | | | | | | | |
| | Check Pressure Areas | | | | | | | | |
| | Nail Care | | | | | | | | |
| | Oral Care | | | | | | | | |
| | Clean Dentures | | | | | | | | |
| | Other (specify): | | | | | | | | |
| PROCEDURES | Assist with Elimination | | | | | | | | |
| | Catheter Care | | | | | | | | |
| | Ostomy Care | | | | | | | | |
| | Record Intake/Output | | | | | | | | |
| | Inspect/Reinforce Dressing | | | | | | | | |
| | Medication Reminder | | | | | | | | |
| | Other (specify): | | | | | | | | |
| ACTIVITY | Assist with Ambulation W/C / Walker / Cane | | | | | | | | |
| | Assist with Mobility Chair / Bed / Dangle / Commode Shower / Tub | | | | | | | | |
| | ROM Active / Passive Arm R / L Leg R / L | | | | | | | | |
| | Positioning - Encourage Assist every _____ hours | | | | | | | | |
| | Exercise - Per PT/OT/SLP Care Plan | | | | | | | | |
| | Other (specify): | | | | | | | | |
| NUTRITION | Meal Preparation | | | | | | | | |
| | Assist with Feeding | | | | | | | | |
| | Limit/Encourage Fluids | | | | | | | | |
| | Grocery Shopping | | | | | | | | |
| | Other (specify): | | | | | | | | |
| OTHER | Wash Clothes | | | | | | | | |
| | Light Housekeeping Bedroom / Bathroom / Kitchen Change Bed Linen | | | | | | | | |
| | Equipment Care | | | | | | | | |
| | Other (specify): | | | | | | | | |

**SIGNATURES/DATES**

**Employee** _____ / / *Date* **Patient** _____ / / *Date*

PATIENT NAME - Last, First, Middle Initial | ID#

 

BRIGGS Healthcare

AIDE WEEKLY VISIT RECORD