

Consumer Name: _____

Provider Name: _____

AM Shift (indicate AM services with X in box of care provided)

Day	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
Date							
Time In:							
Time Out:							
Consumer Signature:							
Provider Signature:							

PM Shift (indicate PM service with a ✓ in box of care provided)

Day	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
Date							
Time In:							
Time Out:							
Consumer Signature:							
Provider Signature:							

Personal Care: Su M T W Th F S
 Bath:
 Oral Care:
 Shampoo:
 Toileting:
 Dressing:
 Grooming:

Outside Home: Su M T W Th F S
 Shopping:
 Errands:
 Therapy:
 Dr. Appointment:
 _____:
 _____:

Meal Prep: Su M T W Th F S
 Breakfast:
 Lunch:
 Dinner:
 Snack:

Behavior: Su M T W Th F S
 Happy:
 Angry:
 Sad:
 Tearful:
 _____:
 _____:
 _____:

Cleaning: Su M T W Th F S
 Dishes:
 Sweep:
 Mop:
 Trash:
 Bedroom:
 Bathroom:
 Living Room:

Activities: Su M T W Th F S
 Games:
 Reading:
 Videos:
 _____:
 _____:

Utilize Daily Narrative to specify the amount of time involved with the care activities done during AM and PM shift.

Include in note any contact with case managers, family, physicians or other individuals involved with the consumer's care.