Exceptional Hearts Home Care

Hourly Time Sheets

Employee Name_____ Pay Period Start Monday ____/____/_____

Client Name: _____ Pay Period End Sunday ____/____/_____

Day	Date	Shift	# of Hours
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			
		Total Hours for pay period	

During this pay period, did your client have a hospital admission? _____

If yes which days_____

Employee Signature _____ Date: _____

Falsified documentation is grounds for immediate termination.
Time sheets are due every MONDAY by 5:00pm

Fax: (215)455-1114 **Email: exceptionalhearts@gmail.com**

Exceptional Hearts Homecare Agency, LLC

Aide Weekly Flow Sheet

Patient Name			MON	TUE	WED	THU	FRI	SAT	SUN
MR#		DATE:							
		START TIME: END TIME:							
		RSN – Patient Refused Nurse Notified:	PRNN	PRNN	PRNN	PRNN	PRNN	PRNN	PRNN
Vital Signs	Record Temperature:								
	Record Pulse								
	Record Respirations								
	Record Blood Pressure								
	Record Weight								
Hygiene	Bath: 0 Bed0 Tub 0 Shower 0 Sponge								
	Peri Care Foley Care								
	Hair: 0 Shampoo 0 Brush 0 Comb								
	Oral Care:0 Mouth 0 Teeth 0 Dentures								
	Shave								
	Nail Care (file only, do not cut)								
	Apply Lotion/Powder to Skin								
	Dress Patient: 0Partial Assist 0 Complete								
	Other:								
Bowel & Bladder	Assist with Toileting: 0 Bedpan 0 Commode 0 Bathroom								
	Measure Urine Output: 0 Record Color								
	Record Bowel Movement: 0 Record Consistency								
	Incontinent Care: 0 Bladder 0 Bowel								
	Other								
Dietary	Meal: 0 Prep 0 Assist 0 Feed 0 Special Diet 0 Record Appetite								
	Assist with Medications: (reminder only)								
	Assist with Oxygen: Tubing & Cannula Care								
	Assist Nurse with Patient Care								
	Other								
Musculoskeletal	Turn and Reposition Q 2 Hours: 0 Bed 0 Chair								
	Assist Exercises: 0 PT0 OT0 ST 0 ROM								
	Transfer Patient to: 0 Bed 0 Chair 0 Commode 0 Use Hoyer Lift 0 Max 0 Min 0 Standby Assist								
	Ambulate Patient: 0 Assistance 0 Supervision 0 Walker 0 Cane 0 Quad Cane 0 Crutches								
	Other								
Environment	Change Bed /Made Bed								
	Clean Bathroom								
	Keep Kitchen Clean & Workable								
	Clean Patient Area								
	Wash Patient's Laundry & Bed Linens								
	Safety check								
	Grocery Shopping								
	Other								
	PATIENT, INITIALS:								
	HHA INITIALS:								

Patient Signature: _____ **Date:** _____

HHA Signature: _____ **Date:** _____