Employee– 7 Day Shift Report

Name (Last Name First)		Phone Number
Client Name	Employee Signature	Date

Day	Date	Time In	Time Out	Total Time	Miles	Client Signature daily
Sun						
Mon						
Tues						
Wed						
Thurs						
Fri						
Sat						

Are you new to this client? ☐

Plan of Care was reviewed _________

Emergency Procedures were reviewed___________

Please Sign & Initial Below

Caregiver Signature: ______________________________________

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Personal Care							
Bathing							
Shower							
Tub Bath							
Sponge Bath							
Bed Bath							
Skin Care							
Nail Care							
Oral Care							
Shampoo							
Shave							
Foot Care							
Dressing Assistance							
Elimination							
Assist to toilet							
Bedpan/urinal							
Catheter Care							
Empty urine bag							
Bowel Care							
Cooking/Housekeeping							
Meal preparation							
Assist with feeding							
Diet							
Grocery/ shopping							
Vacuuming							
Dusting							
Change sheets							
Laundry							
Clean house							

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Safety							
Fall Precautions							
Seizure Precautions							
O2 Precautions							
24 hr supervision							
Water temp							
Universal Precautions							
Vital Signs							
Pulse							
Respirations							
Blood Pressure							
Temperature							
Weight							
Activities							
Transportation							
Other							
Mobility							
Assist to walk							
Use walker							
Use wheelchair							
Use Cane							
Medication Reminder							

Observations/concerns

Contact Supervisor Yes No