TO INSURE PROPER AND PROMPT PROCESSING OF YOUR CHECK-MAIL AT THE END OF WORK WEEK TO:

X-TREME CARE

Queens (HQ) : 149-08 41st Ave. 2nd FL. Flushing, NY 11355 T: 718-461-9602 F: 718-461-3208
Queens (Main St.) : 36-40 Main St. Rm.306 Flushing, NY 11354 T: 718-461-9602 F: 718-321-3857
Brooklyn : 839 58th St. 4th FL, Brooklyn, NY 11220 T: 718-461-9602 F: 718-972-2569
Bronx : 369 East 149th St. 5th FL, Bronx, NY 10455 T: 718-461-9602 F: 718-220-3845

EMPLOYEE TIME SHEET AND AIDE ACTIVITY SHEET

CLIENT NAME & ADDRESS	VENDOR NAME	COORDINATOR NAME
	EMPLOYEE NAME	
	TYPE OF CASE: ☐ HHA ☐ PCA	S.S. #	OFFICE:

	DATE	SHIFT TIME STARTED	SHIFT TIME LEFT	LIVE IN or HOURS WORKED	DAILY CLIENT SIGNATURE *Please Sign Daily*
MONDAY					
TUESDAY					
WEDNESDAY					
THURSDAY					
FRIDAY					
SATURDAY					
SUNDAY					
TOTAL DAYS WORKED or TOTAL HOURS WORKED					EMPLOYEE *Please Print Name*

X-TREME CARE SERVICE REPORT

INSTRUCTIONS: Activities checked [✓] on this report, must correspond with the nursing care plan completed be the RN. Please [✓] or (R) in appropriate box. ([✓] = Completed (R) = Refused)

ACTIVITIES OF DAILY LIVING (ADL'S)

Date							
Day of Week	MON	TUE	WED	THU	FRI	SAT	SUN
Time (Start - End)							
CHECK CARE GIVEN: (✓ = Performed R = Refused)							
Bathing - ☐ Bed ☐ Shower ☐ Tub							
Skin Care							
Nail Care *(Never Cut Nails)*							
Shave							
Mouth Care							
Foot Care							
Weigh Patient							
Empty Drainage Bag							
Hair Care							
Dressing							
Toileting							
Turn & Position Patient							
Walking (Assist)							
Assist with Transfer							
Remind to Take Medications							
Record Intake/Output							
Special Diet ☐ Diabetic ☐ Low Salt							
☐ Other							
Feed Patient							
Bowel Movement							
Colostomy Care							
Universal Precautions							
Child Care/Supervision							
Bedsore (Decubitus)							

HOMEMAKING DUTIES

Date							
Day of Week	MON	TUE	WED	THU	FRI	SAT	SUN
Time (Start - End)							
CHECK CARE GIVEN: (✓=Performed R= Refused)							
Beds/Bedroom							
Refresh or Change							
Clean/Tidy Bedroom							
Bathroom							
Kitchen Dishes							
Vacuum/Sweep/Mop							
Meal Prep							
Empty Trash/Ash Tray							
Dust (Weekly)							
Laundry							
Shopping/Errands							
Assist with Bill Paying							
Accompany To:							
Other:							
Other:							
Other:							
PROCEDURES FOR HHA CASES							
Temperature							
Pulse ☐ BP							
Respiration							
Change/Reinforce Simple Dressing							
Ostomy Care							
Range of Motion							
Test Urine							
Other:							
Other:							

ANY PROBLEMS OR CHANGES IN CLIENT'S CONDITION MUST BE PHONED INTO THE OFFICE IMMEDIATELY.

I CERTIFY THAT THE INFORMATION SUPPLIED IS ACCURATE AND I AGREE WITH THE TERMS SPECIFIED ON THE REVERSE SIDE OF THIS DOCUMENT.

Employee Signature: ______________ Reviewer's Signature: ______________ Date: ______________