

Client Name: _____

Program: _____ Client #: _____

PCW DUTIES	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Date							
Daily Assistance							
<input type="checkbox"/> Dress/Undress							
<input type="checkbox"/> TEDS Stocking							
<input type="checkbox"/> Tub Bath							
<input type="checkbox"/> Bed Bath or Sponge Bath							
<input type="checkbox"/> Shower							
<input type="checkbox"/> Hair Care							
<input type="checkbox"/> Oral Care							
<input type="checkbox"/> Skin Care							
<input type="checkbox"/> Nail Care							
<input type="checkbox"/> Shaving							
<input type="checkbox"/> Glasses/Hearing Aid							
<input type="checkbox"/> Ambulation (Walking)							
<input type="checkbox"/> Transfer (Hoyer)							
<input type="checkbox"/> Transfer							
<input type="checkbox"/> Positioning							
<input type="checkbox"/> Toileting							
<input type="checkbox"/> Incontinent Care							
<input type="checkbox"/> Catheter Care							
<input type="checkbox"/> Bowel Routine							
<input type="checkbox"/> Splints/Braces– On/Off							
<input type="checkbox"/> Range of Motion Exercises							
<input type="checkbox"/> Accompany to Medical Appt.							
<input type="checkbox"/> Measure I and O							
<input type="checkbox"/> T, P, R, BP							
<input type="checkbox"/> Medication Reminder							
<input type="checkbox"/> Laundry							
<input type="checkbox"/> Dust/Clean							
<input type="checkbox"/> Meal Prep/Feeding							
<input type="checkbox"/> Wash Dishes							
<input type="checkbox"/> Other							

TIME REPORTING FOR FAILED TELEPHONY ONLY							
Time Begin							
Time End							

Client Initials

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Employee (sign & date): _____

RN (sign & date if applicable): _____

Personal Care Telephony Duty List

Gemini Employee Leasing, Inc.

Place Employee Label Here

County: _____ Month: _____ Year: _____

Provider: Please complete and forward to Liaison Supervisor Weekly

1. Were there any changes in the client's overall functioning? Yes No

Was the RN notified of changes? Yes No Date notified _____

If yes, indicate the dates and describe the changes:

2. Were there any changes in the client's physical health

and/or emotional health? Yes No

Was the RN notified of changes? Yes No Date notified _____

If yes, indicate the dates and describe the changes.

3. Were there any cares assigned which were not completed? Yes No

Explain and list dates.

Errands With/For Client:

Please indicate dates you drove clients for authorized errands and also indicate where you drove the client to. Please indicate the number of miles in whole numbers only if telephony recording failed.

Date	Where	Miles	Date	Where	Miles

Client (sign & date): _____