GOLDSTAR

DAILY TIME SHEET AND CARE NOTES

Client Name : _____

		Mon	Tues	Wed	Thurs	Fri	Sat	Sun
DATE								
TIME START								
TIME END								
TOTAL HOURS PER DAY		Hours	Hours	Hours	Hours	Hours	Hours	Hours
CLIENT INITIALS								
Bathing								
Dressing								
Transferring								
Toileting								
Feeding / Eating								
Assist with Ambulation / Mobility								
Incontinence Care								
Catheter / Ostomy Care								
Hair Care								
Nail Care (Do Not Cut Nails)								
Shave Client								
Oral Hygiene								
Bowel Movement								
Aid in Memory Needs / Communication etc.								
Walks for Exercise								
Uses Cane / Walker / Crutches								
Uses Wheelchair								
Range of Motion Exercises								
Reminder to take Medication								
Prepare or Serve Meal								
Grocery Shopping								
Cleaning								
Laundry								
Transportation/Doctors/Bank/Drugstore/Errands								
Light Housekeeping								
TOTAL								

CLIENT _____ DATE_____

CAREGIVER _____ DATE_____