

APremium Healthcare Solution, LLC

Client Service Record Form

CCSP-7xwk @ 3hrs split shift Mon.-Sun 9a-11a & 7p-9p

Emory Allen-770-483-4802

Employee Name:

Month:	Dates:														
DAYS OF SERVICE		SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT
Personal Care Tasks: bathing (tub/shower/bed/towel);															
Grooming: mouth/denure care; skincare; dressing; toileting;															
Medication: medication reminder															
Nutrition: meal preparation															
Housekeeping tasks: Clean bathroom; bedrooms; living room; kitchen wash dishes used by client & change linens, laundry															
Sweep; dust, mop, vacuum, empty trash															
Assisting Transfer/Ambulatory services: client needs assistance in mobility and transfer															
Caregiver Relief: Socializing and providing watchful supervision															
Arrival Time															
Departure Time															
TOTAL HRS Worked															
CLIENT'S INITIAL															

Notes: Document & Report unusual findings to RN/office immediately)

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Diagnosis: Cerebral Palsy 80% blind; mobility impairment; High Fall Risk!!

Clients Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PSS Supervisor's Signature: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: 678-964-2217 & phone: 678-964-2037

To avoid any delay in payments please PRINT and COMPLETE all information requested.