

APremium Healthcare Solution, LLC

Client Service Record Form

CCSP-3xwk @ 3hrs Mon. Wed. Fri. (mornings)

Dorothy Ammons-706-476-2028

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: dressing; grooming mouth/denure care; skincare; toileting;															
Housekeeping tasks: Clean bathroom; bedrooms; & change linens															
Caregiver Relief: Socializing and providing watchful supervision															
Ambulatory Assistance: High fall risk client; watchful supervision req.															
Incontinent Watch: Client wears depends in case of accidents: but continent of bladder															
Arrival Time															
Departure Time															
TOTAL HRS Worked															
CLIENT'S INITIAL															

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

Diagnosis: Dementia & psychosis schizophrenia; seizure D/O & rheumatoid arthritis; High Fall Risk: Low salt diet.

Clients Signature: _____ Date: _____

PSS Supervisor's Signature: _____

Employee Signature: _____ Phone: _____

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