Celestial Care Inc.

110-05 Liberty Ave
S. Richmond Hill, NY 11419

FAX: (929) 386-0777

DAILY TIME SHEET

Name: _____ Week Ending: _____/_____/_____

Patient's Name: _____ Social Security: XXX-XX-_____

Date	Day	Time In	Time Out	Hours	Employee Signature	Client /Family Signature	Supervisor's Signature
	Sun						
	Mon						
	Tues						
	Wed						
	Thur						
	Fri						
	Sat						

Total Hours for the week: **NO SERVICES WILL BE PAID WHEN CLIENT IS HOSPITALIZED. ONLY AUTHORIZED HOURS WILL BE PAID.**

TASK	Sun	M	Tue	W	Thu	Fri	Sat
BATH: ☐Tub 100 ☐Shower 101 ☐Bed 102 PATIENT REQUIRES TOTAL CARE: ☐103							
MOUTH CARE: ☐106 HAIR CARE: ☐Comb 107 ☐Shampoo 108 ☐Foot Care 113							
GROOMING ☐Shave 109 ☐Nails 110 DRESSING ☐ 111 ☐ Skin Care 112							
TOILETING ☐ Diaper 114 ☐ Commode 115 ☐ Bedpan 116 ☐ Toilet 117							
PREPARE ☐ Diet 201 ☐ Breakfast 202 ☐ Lunch 203 ☐ Dinner 204 ☐ Snack 205							
ASSIST WITH FEEDING : ☐ 206 RECORD INTAKE: ☐ Food 207 ☐ Fluid 208							
TRANSFERRING: ☐ 300 ASSIST: ☐ Walking 301 ☐ W/ Devices 302 ☐ Home Exercise 305							
RANGE OF MOTION EXERCISES ☐ 306 TURNING AND POSITIONING ☐ 311							
TAKE: ☐Temperature 400 ☐Pulse 403 ☐Blood Pressure 405 WEIGH PATIENT ☐ 406							
REMIND PATIENT TO TAKE MEDICATION ☐ 411 ASSIST WITH TREATMENT ☐ 412							
ASSIST: ☐Catheter Care 408 ☐Foley bag 409 ☐Ostomy Care 410 SAFETY: ☐511							
TAKE RESPIRATIONS ☐ 506 RECORD OUTPUT (URINE/BM) ☐ 307							
CHANGE PATIENT'S LINEN: ☐ 500 LAUNDRY: ☐ 501 LIGHT HOUSEKEEPING ☐ 502							
CLEAN PATIENT CARE EQUIPMENT ☐ 505 ACCOMPANY PATIENT TO DOCTOR ☐ 508							
SHOPPING/ERRANDS ☐ 506 DIVERSIONAL ACTIVITIES-SPEAK/READ ☐ 509							

FOR LIVE-IN PATIENTS ONLY WEEK STARTING: _____ TO WEEK ENDING: _____

1. 5 Hours Uninterrupted Sleep: Yes ☐ No ☐
   If no, please specify: _____
2. 3 Hours Additional Sleep: Yes ☐ No ☐
   If no, please specify: _____
3. 3 Hours Uninterrupted Meal Time: Yes ☑ No ☑
   If no, please specify: _____

By signing below, I further acknowledge that I had 5 hours of uninterrupted sleep with 3 additional hours of sleep and 3 hours of uninterrupted meal time. I also acknowledge that I have adequate sleeping arrangement in the patient home. I understand that if I do not get my uninterrupted time to sleep, I will immediately inform my agency at admin@celestialhomecare.com
I certify that this form is true and accurate, I also stated that I had no Issues at the patient home, IF i did i will contact my agency.

Caregiver's Signature: _____ **Date:** _____

REMINDER: IN ORDER FOR PAYROLL TO PROCESS YOUR PAYMENT, TIMESHEET MUST BE COMPLETED IN FULL AND SENT OVER TO OUR OFFICE BY NOON ON MONDAYS.

Email to: Timesheet@cottagehomecare.com SEND

Caregiver's Signature: _____ **Date:** _____