

Guardian Angel Health Agency LLC
 639 S. Hamilton Rd Whitehall OH 43213
 Tel: (614)868-3225 Fax: (614)868-3437

PATIENT NAME: _____

DATE	BLOOD PRESSURE	PULSE	RESP	TEMP	BLOOD SUGAR	WEIGHT	NURSE NAME/COMMENT

GUARDIAN ANGEL HEALTH AGENCY, LLC

639 S Hamilton Ave, OH Whitehall 43213 Tel: (614)868-3225 Fax: (614) 868-3437
DODD HOMEMAKER/PERSONAL CARE

CLIENT NAME: _____

DATE / /

DATE	EMPLOYEE NAME (PRINT)	EMPLOYEE SIGNATURE	TIME-IN	TIME-OUT	TOTAL HOURS	CLIENT/GUARDIAN SIGNATURE
			AM PM	AM PM		
			AM PM	AM PM		
			AM PM	AM PM		
			AM PM	AM PM		
			AM PM	AM PM		
			AM PM	AM PM		
			AM PM	AM PM		
			AM PM	AM PM		
			AM PM	AM PM		

Employee Name _____

Signature _____

/ / Date _____

Total Hours _____

Client/Guardian name _____

Signature _____

Date _____

/ / _____

Note: This is a legal document and your signature verifies the work has been done. Form must be signed by the client and staff. USE OF WHITEOUT TO CORRECT TIMESHEET IS NOT ALLOWED AND WILL RESULT IN HOURS NOT PAID. TIMESHEETS ARE DUE IN OFFICE EVERY MONDAY BY 12 NOON NO EXCEPTIONS

As part of documentation, please complete the ISP checklist/Care Plan on a daily basis.

GUARDIAN ANGEL HEALTH AGENCY, LLC

INCIDENT REPORT

Patient MR# _____

Date of Incident _____

TYPE OF INCIDENT

- | | | |
|---|---|--|
| <input type="checkbox"/> Med. error | <input type="checkbox"/> Missed procedure | <input type="checkbox"/> Equipment failure |
| <input type="checkbox"/> Patient fall (no injury) | <input type="checkbox"/> Employee injury | <input type="checkbox"/> Loss or damage property |
| <input type="checkbox"/> Patient fall (with injury) | <input type="checkbox"/> Patient injury | <input type="checkbox"/> Inappropriate behavior |
| <input type="checkbox"/> Threat of OR Attempted Suicide | <input type="checkbox"/> Suspicion of Abuse | |

Other _____

Location _____

Individuals involved: (Please use Patient & Employee's I.D. Numbers)

Name(s) of Witness(es): _____

Description of Incident:

Action Taken:

Physicians notified by: _____ Date _____ Time _____
Name of Physician _____

Interventions to prevent recurrence:

Signature of individual filing report: _____ Date _____

Signature of DOCS/RN: _____ Date _____

