SAFETY FIRST

Granny NANNIES

Weekly Services Delivered

TO BE RECEIVED NO LATER THAN NOON - MONDAY

THINK SAFETY AT ALL TIMES

Client Name: _____ Address: _____

Nanny Name: _____ SSN: _____

20___

Notes: _____

	Day:	M ____/____	T ____/____	W ____/____	TH ____/____	F ____/____	SA ____/____	SU ____/____
	In:							
	Out:							
	Hours:							
	Miles:							

PLEASE NOTE ANY ASSISTANCE WITH HANDS-ON CARE YOU GIVE AS DIRECTED BY CLIENT

Vitals							
Tub bath/Shower/Bed/Sink *(Self / Asst / Total)*							
Shampoo Hair							
Brush / Comb Hair							
Shave Client							
Mouth care							
Dressing *(Self / Asst / Total)*							
Bowel: Normal (N) Diarrhea (D) Constipation (C)							
Incontinent Care Diapers (# of changes)							
Pericare							
Remind Medications							
Turning / Positioning / Transf *(Self / Asst / Total)*							
ROM / Assist w/Exercise							
Hands on Help w/Walking							
Uses Cane / Walker / Crutch							
Bedrest							
Feed Client							
Appetite: Good / fair / Poor							
Visits By Other Agencies							

PLEASE NOTE ANY ASSISTANCE YOU GIVE WITH ANY HOUSEHOLD DUTIES AS DIRECTED BY CLIENT

Bed Made (M) Changed (C)							
Prepare / Serve Meal							
Grocery Shopping / Errand							
Light Cleaning / Vacuuming Patient Area							
Laundry for Patient							
Transportation (Where?) Dr. P.T.							
Client Daily Initials							
Nanny Daily Initials							

PAYMENT

☐ **GN PAY** ☐ **CASH PAY** ☐ **CHECK #:** _____

Total Hours = _____ X Companion Rate $ _____ = $ _____

Certified Rate $ _____ = $ _____

Total Miles = _____ X Mileage Rate $ _____ + $ _____ = **TOTAL DUE $** _____

Client Weekly Signature _____ Date: _____

Nanny Weekly Signature _____ CNA / HHA / Companion Date: _____

It is acknowledged that all services delivered, hours worked and times are true and correct.

WHITE - OFFICE YELLOW - OFFICE PINK - NANNY GOLD - CLIENT

SAFETY FIRST

Granny NANNIES

Weekly Services Delivered

TO BE RECEIVED NO LATER THAN NOON - MONDAY

THINK SAFETY AT ALL TIMES

Client Name: _____ Address: _____

Nanny Name: _____ SSN: _____

20___

Notes: _____

	Day:	M ____/____	T ____/____	W ____/____	TH ____/____	F ____/____	SA ____/____	SU ____/____
	In:							
	Out:							
	Hours:							
	Miles:							

PLEASE NOTE ANY ASSISTANCE WITH HANDS-ON CARE YOU GIVE AS DIRECTED BY CLIENT

Vitals							
Tub bath/Shower/Bed/Sink *(Self / Asst / Total)*							
Shampoo Hair							
Brush / Comb Hair							
Shave Client							
Mouth care							
Dressing *(Self / Asst / Total)*							
Bowel: Normal (N) Diarrhea (D) Constipation (C)							
Incontinent Care Diapers (# of changes)							
Pericare							
Remind Medications							
Turning / Positioning / Transf *(Self / Asst / Total)*							
ROM / Assist w/Exercise							
Hands on Help w/Walking							
Uses Cane / Walker / Crutch							
Bedrest							
Feed Client							
Appetite: Good / fair / Poor							
Visits By Other Agencies							

PLEASE NOTE ANY ASSISTANCE YOU GIVE WITH ANY HOUSEHOLD DUTIES AS DIRECTED BY CLIENT

Bed Made (M) Changed (C)							
Prepare / Serve Meal							
Grocery Shopping / Errand							
Light Cleaning / Vacuuming Patient Area							
Laundry for Patient							
Transportation (Where?) Dr. P.T.							
Client Daily Initials							
Nanny Daily Initials							

PAYMENT

☐ **GN PAY** ☐ **CASH PAY** ☐ **CHECK #:** _____

Total Hours = _____ X Companion Rate $ _____ = $ _____

Certified Rate $ _____ = $ _____

Total Miles = _____ X Mileage Rate $ _____ + $ _____ = **TOTAL DUE $** _____

Client Weekly Signature _____ Date: _____

Nanny Weekly Signature _____ CNA / HHA / Companion Date: _____

It is acknowledged that all services delivered, hours worked and times are true and correct.

WHITE - OFFICE YELLOW - OFFICE PINK - NANNY