For any questions or concerns please contact to 508-583-1157

Healthier You AFC

Caregiver Log

Name of Agency: **Member Name:** **Month/Year:**_____

Activities of Daily Living (ADL) Uses codes: 0-independent (no help needed), 1-Set up, 2-Supervision, 3-Physical Assist, 4-dependent, 8-Activity did not occur supervision and/or Assistance through the task

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Positioning in the bed or chair																															
Transferring																															
Locomotion/Ambulation Home																															
Locomotion/Ambulation Outside																															
Dressing upper body																															
Dressing lower body																															
Eating																															
Bathing																															
Personal Hygeine																															
Toileting																															
Incontinence Care:	Record the number of times scheduled toileting or incontinence care provided.																														
	For catheter care record "C", for colostomy care record "CL"																														
Bowel																															
Bladder																															
Instrumental Activities of Daily Living (IADL) Uses codes: 0-Independent, 1-Some Help, 2- Full Help, 3-By Others, 8-Activity did not occur																															
Meal Preparation																															
Ordinary Housework																															
Managing Finances																															
Managing Medications																															
Phone Use																															
Shopping																															
Trasnportation																															
Other Services	**Check all that occurred**																														
Adult Day Health																															
Alternative Placement																															
Skilled Nursing Visit																															
MD Visit																															
Day Habilitation																															
Other																															
Caregiver Initials																															

Primary Caregiver _____ (Initial/Signature)

Alternate Caregiver _____ (Initial/Signature)

Case Manager _____ (Signature)

Name of Agency: Healthier You AFC **Member Name:** **Month/Year:**_____

Daily Notes: Please note any activity considered out of the ordinary. Please date and initial each note. Use additional paper if necessary.

Behavior	**Intervention**	**Outcome**
1- Wandering	1- 1:1	1- No Change
2- Verbally Abusive Behavior	2- Snack	2- Improved
3- Physically Abusive Behavior	3- Redirection	3- Worsened
4- Socially Inappropriate Behavior	4- Diversion Activity (Per Care Plan)	
5- Resist Care	5- Other (Per Care Plan)_____	
6- Other _____	6- Other:_____	
7- Other _____		

Daily Behavior Intervention

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Behavior document # times/day																																
	1																															
	2																															
	3																															
	4																															
	5																															
	6																															
	7																															
Intervention																																
Easily Redirected																																
Use Codes: 0-No, 1-Yes																																
Outcome																																
Caregiver Initials																																

Primary Caregiver _____
(Initial/Signature)

Alternate Caregiver _____
(Initial/Signature)

Alternate Caregiver _____
(Initial/Signature)

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Healthier You AFC

297 North Main St., Ste. 2
Brockton, MA 02301

Date: ____________________

Caregiver's Name: ____

Client's Name: ____

Monthly Medication Log

Medications:	Time:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	7-3																															
Initials:	3-11																															
	11-7																															

Comments: ____

Nurse First Visit Date: ___ / ___ / ___
Signature: ______________________________

Nurse Second Visit Date: ___ / ___ / ___
Signature: ______________________________

Case Manager Monthly Visit Date: ___ / ___ / ___
Signature: ______________________________