**Patient Care Flow Chart**

Advent One Home Care Agency Service Period

10925 Estate Ln Suite 309 From: To:

Dallas, TX, 75238

Tell: 214-503-6854, Fax: 214-5036853

Client Name: Care Giver Name:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Service Date: | M | T | W | Th | F | S | Su | M | T | W | Th | F | S | Su |
| **Personal Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Companionship |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Bathing Assistance |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Grooming |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Shave |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Oral Hygiene |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Incontinent Care |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Assist with Dressing |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Assist with Exercising |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Ambulation Assist/Transfer |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Medication Reminder |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Hair/Skin Care |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Toileting |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Escort |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Nutrition |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Meal Preparation |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Grocery Shopping |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Meal Planning |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Feeding Assistance |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Home Management |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Light Housekeeping |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Laundry: Clothes/Linens |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Transportation |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Make/Change Bed |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Errands |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Client Signature: Date:

Care Giver Signature: Date:

Advent-One Ma nagement : Date:

*I certify that the care listed is an accurate account of the care given and received*