

CLIENT'S NAME:

Pay Period Coverage

CAREGIVER:

Provider's Name: OptimistPrimeCare,LLC

Phone #: (916) 895-1199

WEEKLY FLOWSHEET

PERSONAL CARE	Sat	Sun	Mon	Tue	Wed	Thu	Fri
Date →							
Bath: <input type="checkbox"/> Shower <input type="checkbox"/> Sponge <input type="checkbox"/> Bed <input type="checkbox"/>							
Dressing <input type="checkbox"/> Physically Assisted <input type="checkbox"/> Verbal Cue <input type="checkbox"/>							
Hair Care: <input type="checkbox"/> Comb <input type="checkbox"/> Shampoo <input type="checkbox"/>							
Skin Care: <input type="checkbox"/> Lotion <input type="checkbox"/>							
Foot Care <input type="checkbox"/> Compression Stockings <input type="checkbox"/>							
Pressure Area Check <input type="checkbox"/>							
Shave <input type="checkbox"/>							
Deodorant <input type="checkbox"/>							
Nail Care/Clean/File (Do Not Cut) <input type="checkbox"/>							
Oral Care: Brush <input type="checkbox"/> Dentures <input type="checkbox"/> Swab <input type="checkbox"/>							
Elimination Assistant: <input type="checkbox"/> Commode <input type="checkbox"/> Urinal <input type="checkbox"/>							
Incontinence Care: Bowel <input type="checkbox"/> Bladder <input type="checkbox"/> Protective Briefs <input type="checkbox"/>							
ACTIVITY							
Ambulation: Physically Assisted <input type="checkbox"/> Standby <input type="checkbox"/>							
Ambulation with Cane/ FWW <input type="checkbox"/>							
Range of Motion <input type="checkbox"/>							
Transfers: To _____ From: _____							
Change of Position/Turning <input type="checkbox"/>							
NUTRITION							
Meal Planning/Preparation <input type="checkbox"/>							
Feeding: <input type="checkbox"/> Spoon Fed <input type="checkbox"/> Verbal Cue <input type="checkbox"/>							
Record Intake/Output <input type="checkbox"/>							
Grocery Shopping <input type="checkbox"/>							
HOME MAKING							
Light Housekeeping: <input type="checkbox"/> Dusting <input type="checkbox"/> Vacuum <input type="checkbox"/>							
Sweeping <input type="checkbox"/> Mopping <input type="checkbox"/>							
Bedroom/Bathroom/Kitchen/Living Room <input type="checkbox"/>							
Change Linens/Laundry <input type="checkbox"/>							
Recreational Activities <input type="checkbox"/>							
Medication Reminders <input type="checkbox"/>							
Transportation <input type="checkbox"/>							
Errands/Shopping <input type="checkbox"/>							
Companion Services <input type="checkbox"/>							
Others: <input type="checkbox"/>							

WEEKLY TIMESHEET

DAY	DATE	IN	OUT	HOURS	CLIENTS SIGNATURE	NO. MILES
SAT						
SUN						
MON						
TUE						
WED						
THU						
FRI						
TOTAL						
CAREGIVER'S SIGNATURE						

I certify that I have worked the hours listed on this sheet and take breaks by applicable law while on this assignment. I have not had any work related injuries that I have not reported to OPC Caregivers.

Note to caregivers: Please put check (✓) marks on the boxes for the tasks you performed on the corresponding dates/days

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