Adult Family Care   **Caregiver Log**

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

	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

Activities of Daily Living (ADL) Use 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 throughout 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 bed or chair																															
Transferring																															
Locomotion/ambulation home																															
Locomotion/ambulation outside																															
Dressing upper body																															
Dressing lower body																															
Eating																															
Bathing																															
Personal Hygiene																															
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) Use codes: 0-Independent, 1-Some Help, 2-Full Help, 3-By others, 8-Activity did not occur

	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
Meal Preparation																															
Ordinary Housework																															
Managing Finances																															
Med Mgmt.--Taken as prescribed																															
Phone Use																															
Shopping																															
Transportation																															

Other Services   **Check all that occurred**

	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
Adult Day Health																															
Alternative Placement																															
Skilled Nursing Visit																															
MD visit																															
Hospitalized																															
ER visit																															
Day Habilitation																															
Other																															

Caregiver Initials																															

Reviewed by: _____   RN ☐   CM ☐

Primary Caregiver Signature: _____   Date of Review: _____

Alternate Caregiver Signature: _____   Level of Care: I ☐   II ☐   Rev. 12/20

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- Resists Care	5- Other (per Care Plan _____	
6- Other: _____	6- Other: _____	
7- Other: _____		

Daily Behavior Intervention

Behavior document # times/day	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
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) _____