

CAREGIVER'S CHECKLIST

Patient name: _____

Date: _____

Activities and exercise

| Activity | Duration |
|----------|----------|
| | |
| | |
| | |

Meal

| Meal | Time | Amount |
|------|------|--------|
| | | |
| | | |
| | | |

Medicines

| Medicine | Time | Dosage |
|----------|------|--------|
| | | |
| | | |
| | | |

Bathroom

| | | |
|--|--|--|
| | | |
| | | |
| | | |

Supplies

| | | |
|--|--|--|
| | | |
| | | |
| | | |
| | | |

Personal Care

| |
|--------------------------|
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |

Physical therapy

| |
|--------------------------|
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |

Housekeeping

| |
|--------------------------|
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |
| <input type="checkbox"/> |

Caregiver

Name: _____

Signature: _____