Reset Form

Shift Summary

Client Name		Client ID	

Effective Date		Author	

Shift Overview

Did individual sleep during the shift? ☐ Yes ☐ No ☐ Not Applicable
Comments

Community activities ☐ Yes ☐ No
If yes, please comment

Family/Visitor involvement during shift ☐ Yes ☐ No
If yes, please comment

Medical issues ☐ Yes ☐ No
If yes, please comment

Shift Summary

Behavior issues ☐ Yes ☐ No

If yes, please comment

Shift Note

Indicate what occurred during the shift, include any other information not noted above

Program Name			
Signature		**Date**	
Printed Name & Credentials			

Co-Signature		**Date**	
Printed Name & Credentials			