



Calgary Progressive Lifestyles Foundation

Providing Services for Citizens with DisAbilities

Shift Report

Client's Name: _____ Date: _____

Prepared by: _____

Type and Dates of Support: _____

Activities: _____

Health / Medication: (appetite, medication, administration, energy level etc.)

Behaviors: (any behavioral concerns, mood, etc.?) _____

Did the client:

Make choices about activities? Yes No

Express satisfaction with support? Yes No

Report any concerns or abuse? Yes No

Demonstrate any safety issues? Yes No

General comments / Recommendations / Information for Next Shift:

Staff Signature: _____ Date: _____

Case Manager: _____ Date: _____