## Annexe 2

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Administration des médicaments prescrits réguliers**  Directives aux aides-soignants | | | **Nom :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Prénom :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date de naissance :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Voie** | **Précisions** | **Directives** | | **Date** | **Initiales** | **Cessé** | |
| **Date Initiales** | |
| ** Orale** |  **Comprimé**   Dosette/pilulier   Contenant original   Sachets   **Autre forme**   Pulvérisateur   **Liquide/sirop**   Seringue   Gobelet gradué |  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
| ** Topique** |  Crème/onguent   Poudre/pâte   Produit bain   Lotion/shampoing |  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
| ** Inhalation** |  Aérosol doseur   Nébuliseur   Inhalateur (poudre) |  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
| ** Ophtalmique**   Droit   Gauche |  Gouttes   Onguent |  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
| ** Nasale**   Droit   Gauche |  Gouttes   Vaporisateur |  | |  |  |  |  |
|  | |  |  |  |  |
| ** Auriculaire**   Droit   Gauche |  Gouttes   Huile |  | |  |  |  |  |
|  | |  |  |  |  |
| ** Rectale**  ** Colostomie** |  Suppositoire   Lavement   Crème/onguent/gel |  | |  |  |  |  |
|  | |  |  |  |  |
| ** Vaginale** |  Ovule/suppositoire   Crème/onguent |  | |  |  |  |  |



**Recto**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Nom de l’usager : Date de naissance :** | | | | | | |
| **Voie** | **Précisions** | **Directives** | **Date** | **Initiales** | **Cessé** | |
| **Date Initiales** | |
| **Transdermique**   Timbre   Rotation du timbre | **1**  **2**  **4**  **3**  **9**  **10**  **5**  **7**  **6**  **8** |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Insuline sous‑cutanée**   30 minutes avant le repas   Régulier   Selonéchelle   Seringue préremplie   Stylo   Rotation du site d’injection | Résultat de recherche d'images pour "schéma sites insuline" |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| ** Glycémie capillaire**   Avant déjeuner   Avant dîner   Avant souper   Avant coucher |  Manifestations d’hypoglycémie à surveiller :   Appliquer protocole en cas d’hypoglycémie si : |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  **Entérale** |  |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Signature du professionnel** | **Profession** | **Initiales** | **Signature du professionnel** | **Profession** | **Initiales** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Verso**

## Annexe 3

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Administration des médicaments prescrits réguliers**  Enregistrement par les aides-soignants | | | | | | | | | **Nom :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Prénom :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date de naissance :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
| **Mois :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (changer de formulaire chaque mois) **Année**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Légende pour la médication non administrée :**  R : refus INA : insuline non administrée M : médication manquante S : sortie à l’extérieur H : hospitalisation | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Identification médicaments**   * Si un seul médicament, inscrire son nom * Si plusieurs médicaments regroupés, indiquer les moments où les sachets sont administrés * Si timbre ou insuline, indiquer les sites selon les jours avec le nom du médicament | | **Jour** | | **1** | **2** | **3** | **4** | **5** | | | **6** | **7** | | **8** | | **9** | **10** | **11** | **12** | | **13** | | **14** | | | **15** | **16** |
| **Heures** | | **L’aide-soignant appose ses initiales**  **sous la date et sur la ligne de l’heure d’administration** | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | |  |  |  |  |  | | |  | |  |  | |  |  |  |  |  | |  | | |  | |  |
|  | |
|  | |  | |  |  |  |  |  | | |  | |  |  | |  |  |  |  |  | |  | | |  | |  |
|  | |
|  | |  | |  |  |  |  |  | | |  | |  |  | |  |  |  |  |  | |  | | |  | |  |
|  | |
|  | |  | |  |  |  |  |  | | |  | |  |  | |  |  |  |  |  | |  | | |  | |  |
|  | |
|  | |  | |  |  |  |  |  | | |  | |  |  | |  |  |  |  |  | |  | | |  | |  |
|  | |
|  | |  | |  |  |  |  |  | | |  | |  |  | |  |  |  |  |  | |  | | |  | |  |
|  | |
|  | |  | |  |  |  |  |  | | |  | |  |  | |  |  |  |  |  | |  | | |  | |  |
|  | |
|  | |  | |  |  |  |  |  | | |  | |  |  | |  |  |  |  |  | |  | | |  | |  |
|  | |
| **Signature** | **Initiales** | | **Signature** | | | | | | | **Initiales** | | | | | **Signature** | | | | | | | | | **Initiales** | | | |
|  |  | |  | | | | | | |  | | | | |  | | | | | | | | |  | | | |
|  |  | |  | | | | | | |  | | | | |  | | | | | | | | |  | | | |
|  |  | |  | | | | | | |  | | | | |  | | | | | | | | |  | | | |
|  |  | |  | | | | | | |  | | | | |  | | | | | | | | |  | | | |

**Recto**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Nom de l’usager : Date de naissance :** | | | | | | | | | | | | | | | | | | | | | |
| **Mois :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (changer de formulaire chaque mois) **Année**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Légende pour la médication non administrée :**  R : refus IND : insuline non administrée M : médication manquante S : sortie à l’extérieur H : hospitalisation | | | | | | | | | | | | | | | | | | | | | |
| Identification de la médication | Jour | | 17 | 18 | | 19 | 20 | 21 | 22 | 23 | | 24 | 25 | | 26 | 27 | 28 | 29 | 30 | | 31 |
| Heures | | Apposer vos initiales dans les cases appropriées ci-dessous  selon le jour et l’heure de l’administration | | | | | | | | | | | | | | | | | | |
|  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |
|  |
|  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |
|  |
|  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |
|  |
|  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |
|  |
|  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |
|  |
|  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |
|  |
|  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |
|  |
|  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |
|  |
|  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |
|  |
|  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |
|  |
|  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |
|  |
|  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |
|  |
| Signature | | Initiales | | | Signature | | | | | | Initiales | | | Signature | | | | | | Initiales | |
|  | |  | | |  | | | | | |  | | |  | | | | | |  | |
|  | |  | | |  | | | | | |  | | |  | | | | | |  | |
|  | |  | | |  | | | | | |  | | |  | | | | | |  | |

**Verso**

## Annexe 4

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Administration des médicaments au besoin (PRN)**  Directives aux aides-soignants | | | Nom : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Prénom : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date de naissance : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Voie** | **Précisions** | **Directives et motif d’administration** | | **Date** | **Initiales** | **Cessé** | |
| **Date Initiales** | |
| ** Orale** |  **Comprimé**   Dosette/pilulier   Contenant original   Sachets   **Autre forme**   Pulvérisateur   **Liquide/sirop**   Seringue   Gobelet gradué |  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
| ** Topique** |  Crème/onguent   Poudre/pâte   Produit bain   Lotion/shampoing |  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
| ** Inhalation** |  Aérosol doseur   Nébuliseur   Inhalateur (poudre) |  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
| ** Ophtalmique**   Droit   Gauche |  Gouttes   Onguent |  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |

**Recto**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Nom de l’usager : Date de naissance :** | | | | | | |
| **Voie** | **Précisions** | **Directives et motifs d’administration** | **Date** | **Initiales** | **Cessé** | |
| **Date Initiales** | |
| ** Nasale**   Droit   Gauche |  Gouttes   Vaporisateur |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| ** Auriculaire**   Droit   Gauche |  Gouttes   Huile |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| ** Rectale**  ** Colostomie** |  Suppositoire   Lavement   Crème/onguent/gel |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| ** Vaginale** |  Ovule / suppositoire   Crème/onguent |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| ** Entérale** |  Comprimé   Liquide   Autre |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| ** Insuline sous-cutanée** |  Seringue préremplie   Stylo   Préciser le site : |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Signature du professionnel** | **Profession** | **Initiales** | **Signature du professionnel** | **Profession** | **Initiales** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Verso**

## Annexe 5

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Administration des médicaments au besoin (PRN)**  **Enregistrement par les aides-soignants** | | | | **Nom :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Prénom :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date de naissance :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Identification du médicament**   * Inscrire le nom du médicament * Inscrire la raison d’administration * Indiquer la quantité (qté) : ml, nombre de comprimés * Indiquer la fréquence | **Date :** | | | **Date :** | | | **Date :** | | |
| **Heure** | **Qté** | **Initiales** | **Heure** | **Qté** | **Initiales** | **Heure** | **Qté** | **Initiales** |
| **Médicament et raison d’administration** |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |
|  |  |  |  |  |  |  |  |  |  |
|  |
|  |  |  |  |  |  |  |  |  |  |
|  |
|  |  |  |  |  |  |  |  |  |  |
|  |
| **Médicament et raison d’administration** |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |
|  |  |  |  |  |  |  |  |  |  |
|  |
|  |  |  |  |  |  |  |  |  |  |
|  |
|  |  |  |  |  |  |  |  |  |  |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Signature | Initiales | Signature | Initiales | Signature | Initiales |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Recto**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Nom de l’usager : Date de naissance :** | | | | | | | | | |
| **Identification du médicament**   * Inscrire le nom du médicament * Inscrire la raison d’administration * Indiquer la quantité (qté) : ml, nombre de comprimés * Indiquer la fréquence | **Date :** | | | **Date :** | | | **Date :** | | |
| **Heure** | **Qté** | **Initiales** | **Heure** | **Qté** | **Initiales** | **Heure** | **Qté** | **Initiales** |
| **Médicament et raison d’administration** |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |
|  |  |  |  |  |  |  |  |  |  |
|  |
|  |  |  |  |  |  |  |  |  |  |
|  |
|  |  |  |  |  |  |  |  |  |  |
|  |
|  |  |  |  |  |  |  |  |  |  |
|  |
| **Médicament et raison d’administration** |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |
|  |  |  |  |  |  |  |  |  |  |
|  |
|  |  |  |  |  |  |  |  |  |  |
|  |
|  |  |  |  |  |  |  |  |  |  |
|  |
|  |  |  |  |  |  |  |  |  |  |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Signature | Initiales | Signature | Initiales | Signature | Initiales |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Verso**

## Annexe 6

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Soins invasifs et non invasifs d’assistance aux activités de la vie quotidienne (AVQ)**  Directives aux aides-soignants | | **Nom :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Prénom :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date de naissance :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Activités de soins**  \* Soins invasifs nécessitant une formation et une autorisation par un professionnel habilité | **Directives** | **Date** | **Initiales** | **Cessé** | |
| **Date Initiales** | |
| **Élimination intestinale**   Stimulation réflexe anal\*  Tube rectal\*   Toucher rectal\*  Curage rectal\*  **Stomie intestinale**   Dilatation\*  Irrigation\*   Remplacement / vidange appareil collecteur |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Élimination urinaire**   Cathétérisme\*  Mesure de l’urine   Installation condom urinaire   Irrigation vésicale à circuit ouvert\*   Entretien du système de drainage (à préciser)  **Stomie urinaire**   Dilatation\*   Remplacement/vidange appareil collecteur |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Système respiratoire**   Concentrateur  Cylindre  CPAP   Lunette nasale  Masque  BPAP   Aspiration des sécrétions\*  **Trachéostomie**   Soins canule interne\*   Entretien (à préciser) |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Recto**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Nom de l’usager :** **Date de naissance :** | | | | | |
| **Activités de soins**  \* Soins invasifs nécessitant une formation et une autorisation par un professionnel habilité | **Directives** | **Date** | **Initiales** | **Cessé** | |
| **Date Initiales** | |
| **Système digestif**   Gavage\*  Irrigation\*   Soins   Tube nasogastrique\*  Gastrostomie\*   Stomie\*   Autre (à préciser) : |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Paramètres vitaux**   Pression artérielle    Fréquence cardiaque   Respiration  Saturation   Température :   Buccale  Rectale\* |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  Bas de compression   Application de pellicule / pansement   Prise de glycémie |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Autres activités de soins et directives** | | | | | |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Signature du professionnel** | **Profession** | **Initiales** | **Signature du professionnel** | **Profession** | **Initiales** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Verso**

## Annexe 7

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Soins invasifs et non invasifs d’assistance aux activités de la vie quotidienne (AVQ)**  Enregistrement par les aides-soignants | | | | | | | | | **Nom :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Prénom : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date de naissance : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | |
| **Mois :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (changer de formulaire chaque mois) **Année**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | |
| **Activités de soins** | | **jour** | | **1** | **2** | **3** | **4** | **5** | | **6** | | **7** | **8** | | **9** | **10** | **11** | **12** | **13** | **14** | | **15** | **16** |
| **Heures** | | **Apposer vos initiales dans les cases appropriées ci-dessous**  **selon le jour et l’heure de l’administration** | | | | | | | | | | | | | | | | | | | |
|  | |  | |  |  |  |  |  | |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
|  | |  | |  |  |  |  |  | |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
|  | |  | |  |  |  |  |  | |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
|  | |  | |  |  |  |  |  | |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
|  | |  | |  |  |  |  |  | |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
|  | |  | |  |  |  |  |  | |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
|  | |  | |  |  |  |  |  | |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
|  | |  | |  |  |  |  |  | |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
|  | |  | |  |  |  |  |  | |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
| **Signature** | **Initiales** | | **Signature** | | | | | | | | **Initiales** | | | **Signature** | | | | | | | **Initiales** | | |
|  |  | |  | | | | | | | |  | | |  | | | | | | |  | | |
|  |  | |  | | | | | | | |  | | |  | | | | | | |  | | |
|  |  | |  | | | | | | | |  | | |  | | | | | | |  | | |

**Recto**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Nom de l’usager : Date de naissance :** | | | | | | | | | | | | | | | | | | | | | |
| **Mois :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (changer de formulaire chaque mois) **Année**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
| **Activités de soins** | | **jour** | | **17** | **18** | **19** | **20** | **21** | | **22** | **23** | | **24** | **25** | **26** | **27** | **28** | **29** | | **30** | **31** |
| **Heures** | | **Apposer vos initiales dans les cases appropriées ci-dessous**  **selon le jour et l’heure de l’administration** | | | | | | | | | | | | | | | | | |
|  | |  | |  |  |  |  |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
|  | |  | |  |  |  |  |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
|  | |  | |  |  |  |  |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
|  | |  | |  |  |  |  |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
|  | |  | |  |  |  |  |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
|  | |  | |  |  |  |  |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
|  | |  | |  |  |  |  |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
|  | |  | |  |  |  |  |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
|  | |  | |  |  |  |  |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
|  | |  | |  |  |  |  |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
|  | |  | |  |  |  |  |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
|  | |  | |  |  |  |  |  | |  |  | |  |  |  |  |  |  | |  |  |
|  | |
| **Signature** | **Initiales** | | **Signature** | | | | | | **Initiales** | | | **Signature** | | | | | | | **Initiales** | | |
|  |  | |  | | | | | |  | | |  | | | | | | |  | | |
|  |  | |  | | | | | |  | | |  | | | | | | |  | | |
|  |  | |  | | | | | |  | | |  | | | | | | |  | | |

**Verso**

## Annexe 8

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Soins invasifs et non invasifs d’assistance aux activités de la vie quotidienne (AVQ)**  Observations des aides-soignants | | | | | | **Nom :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Prénom :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date de naissance :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Date** | **Heure** | **Activités de soins** | | | **Observations** | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
|  |  |  | | |  | | | | |
| **Signature** | | | **Initiales** | **Signature** | | | **Initiales** | **Signature** | **Initiales** |
|  | | |  |  | | |  |  |  |
|  | | |  |  | | |  |  |  |
|  | | |  |  | | |  |  |  |

**Recto**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Nom de l’usager : Date de naissance :** | | | | | | | | |
| **Date** | **Heure** | **Activités de soins** | | | **Observations** | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
|  |  |  | | |  | | | |
| **Signature** | | | **Initiales** | **Signature** | | **Initiales** | **Signature** | **Initiales** |
|  | | |  |  | |  |  |  |
|  | | |  |  | |  |  |  |
|  | | |  |  | |  |  |  |

**Verso**