PRESTIGE HOME HEALTH CARE

HOME HEALTH/HOME CARE AIDE WEEKLY VISIT RECORD

EMPLOYEE NAME/TITLE ____________________

EMPLOYEE NO. ____________

When completing be sure to follow the Aide Assignment Sheet/Care Plan

DAY-	SUN	MON	TUE	WED	THU	FRI	SAT	WEEK OF
DATE								/ /
TIME IN:	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	THROUGH
TIME OUT:	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	/ /

	ACTIVITIES	SUN	MON	TUE	WED	THU	FRI	SAT	COMMENTS (All comments must be dated)
VITALS	T ____________								
	P ____________								
	R ____________								
	Weight / Pain Rating (0 - 10 scale)								
BATH	Tub / Shower								
	Bed Bath - Partial/Complete								
	Assist Bath Chair								
HYGIENE/GROOMING	Personal Care								
	Assist with Dressing								
	Hair Care								
	Shampoo								
	Skin Care								
	Foot Care								
	Check Pressure Areas								
	Nail Care								
	Oral Care								
	Clean Dentures								
	Other (specify):								
PROCEDURES	Assist with Elimination								
	Catheter Care								
	Ostomy Care								
	Record Intake/Output								
	Inspect/Reinforce Dressing								
	Medication Reminder								
	Other (specify):								
ACTIVITY	Assist with Ambulation - WC/Walker/Cane								
	Assist with Mobility: Chair Bed/ Dangle/Commode/Shower/Tub								
	ROM Active/Passive Arm R/L Leg R/L								
	Positioning-Encourage Assist _______ hrs								
	Exercise Per PT/0T/SLP Care Plan								
	Other (specify):								
NUTRITION	Meal Preparation								
	Assist with Feeding								
	Limit/Encourage Fluids								
	Grocery Shopping								
	Other (specify):								
OTHER	Wash Clothes								
	Light Housekeeping - Bedroom/Bath-room/Kitchen - Change Bed Linen								
	Equipment Care								
	Other (specify):								
	Last Bowel Movement								

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☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS

☐ Communication with Agency/Supervisor:____________________

EMPLOYEE SIGNATURE/DATE:

Signature: ______________________________ / / Date

PATIENT/CLIENT NAME Last First Middle Initial | MR #

care force, inc. "Home Health Agency"

HOME HEALTH/HOME CARE AIDE WEEKLY VISIT RECORD

EMPLOYEE NAME ______________________

EMPLOYEE NO. ______________________

When completing be sure to follow the Aide Assignment Sheet

DAY-	SUN	MON	TUE	WED	THU	FRI	SAT	WEEK OF
DATE								/ /
TIME IN:								THROUGH
TIME OUT:								/ /

	ACTIVITIES	SUN	MON	TUE	WED	THU	FRI	SAT	COMMENTS (All comments must be dated)
VITALS	T ______________								
	P ______________								
	R ______________								
BATH	Shower								
	Bed Bath								
	Chair Bath								
HYGIENE/GROOMING	Personal Care								
	Assist with Dressing								
	Hair Care								
	Shampoo								
	Skin Care								
	Check Pressure Areas								
	Oral Care								
	Clean Dentures								
	Other (specify):								
PROCEDURES	Assist with Elimination								
	Catheter Care								
	Ostomy Care								
	Record Intake/Output								
	Inspect/Reinforce Dressing								
	Medication Reminder:								
	Other (specify):								
ACTIVITY	Ambulation Assist - WC/Walker/Cane								
	Assist with Mobility: Chair Bed/ W/C /Commode/Shower Chair								
	Positioning - Encourage Assist _______ hrs								
	Other (specify):								
NUTRITION	Meal Preparation								
	Assist with Feeding								
	Grocery Shopping								
OTHER	Wash Clothes								
	Light Housekeeping - Bedroom/Bath-room/Kitchen - Change Bed Linen								
	Equipment Care								
	Comments:								
	PATIENT INITIAL								

SIGNATURES/DATES

Employee ______________________ / / *Date* Patient/Client ______________________ / / *Date*

PATIENT/CLIENT NAME Last First Middle Initial	MR #

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HOME HEALTH/HOME CARE AIDE WEEKLY VISIT RECORD

EMPLOYEE NAME ______________________

EMPLOYEE NO. ______________________

PATIENT/CLIENT NAME - Last, First, Middle Initial	ID#	Patient/Client Signature	/ / Date

When completing, be sure to follow the Aide Assignment Sheet codes.

DAY-	SUN	MON	TUE	WED	THU	FRI	SAT	WEEK OF
DATE								/ /
TIME IN								THROUGH
TIME OUT								/ /
AIDE's INITIALS								
PATIENT'S/CLIENT'S INITIALS								

	ACTIVITIES	SUN	MON	TUE	WED	THU	FRI	SAT	
BATH	Bed - Tub/Shower								
	Bed Bath Partial/Complete								
	Assist Bath Chair								
HYGIENE/GROOMING	Personal Care								
	Assist with Dressing								
	Hair Care Brush/Shampoo/Other								
	Skin Care/Foot Care (Hygiene)								
	Check Pressure Areas								
	Shave/Groom/Deodorant								
	Nail Hygiene - Clean/File/Report								
	Oral Care - Brush/Swab/Dentures								
	Elimination Assist								
	Diaper Change/Perineal Care								
PROCEDURES	Catheter Care								
	Ostomy								
	Record Output/Input								
	Inspect/Reinforce Dressing								
	Assist with Medications								
VITALS	T - Oral/Auxiliary/Rectal								
	Pulse - Site and Results								
	Respiration - Results								
	BP - Site and Results								
	Weight - Results								
ACTIVITY	Ambulation Assist - WC/Walker/Cane								
	Mobility Assist								
	ROM - Active/Passive								
	Positioning Encourage/Assist to Turn q _______Hrs								
	Exercise - Per PT/OT/SLP Care Plan								
NUTRITION	Diet Order:								
	Meal Preparation								
	Assist with Feeding								
	Limit/Encourage Fluids								
	Grocery Shopping								
	Wash Clothes								
	Light Housekeeping - Bedroom/Bathroom/Kitchen - Change Bed Linen								
	Equipment Care								
	Assist with Pain Management								

SIGNATURE/DATE

Employee ______________________ / / Date

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Abana Health Care, Inc.

HOME HEALTH AIDE NOTE

Patient's Name: ____________________ (Please Print)   HHA Name: ____________________ (Please Print)

Patient's Number ____________________   HHA Number ____________________

DATE OF SERVICES / FECHA DE SERVICIOS							
MENTAL STATUS	SUN	MON	TUE	WED	THU	FRI	SAT
Alert / Alerta							
Confused / Confuso							
Forgetful / Olvidadizo							
Unresponsive / No **responde**							
BATHING / PERSONAL CARE							
Bed Bath / Baño en cama							
Tub Bath / Baño en la bañero							
Shower / Ducha / Sitting / Sentado / Standing / De pie							
Mouth Care / Cuidado de la Boca							
Shampoo / Champu							
Shave / Afeitar							
Lotion Massage / Masage con Loción							
Nail Care / Cuidado de las Uñas (No clipping)							
Dressing Assistance / Asistir en Vestir **Cliente**							
TRANSFER / AMBULATION							
Transfers Assist / Asistir en Transferir Cliente							
Up in Chair / Sentar en silla							
Reposition Bed Patient / Reposicionar Paciente en Cama / Bedbound							
Range of Motion / Ejercicios de movimlento							
Ambulate with Assist / Asistencia para ambular							
Ambulate with Cane / Walker / Ambular con Bastón / Andador							
NUTRITION							
Meal Preparation / Preparar comida							
Assist with Feeding / Asistir Cliente a Comer							
ELIMINATION							
Client to Toilet / LLevar el Cliente al Inodoro							
Client to Bedside Commode / Cliente al Inodoro Portatil							
Incontinent Care / Diapers / Cuidado de Incontinencia / Pañales							
Urine / Normal / Abnormal							
Last BM / Ultima vez al baño							
HOMEMAKING TASKS							
Laundry / Lavar							
Grocery Shopping Done / Ir al Mercado							
Kitchen / Cocina							
Bathroom / Baño							
Client's Bedroom / Dormitorio							
TPR							
Temperature							
Pulse							
Respiration							

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DAY	DATE	COMMENTS
SUNDAY		
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
SATURDAY		

I hereby certify that the information contained in this document is true, and have performed all services in accordance to Agency policy
I certify that I have received no injuries during this assignment.

HHA Signature: ____________________
(Firma de asistente)

Nursing Association, Inc.

HOME HEALTH AIDE FLOW SHEET

Patient:______________________ CR#:__________ Emp.#__________

Month 20		Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Temperature	Pulse							
	Respirations							
Bath: Bed	Commode							
Shower	Tub							
Oral Care	Back Rub							
Shampoo	Shave							
Feed Patent	Encourage Fluids							
Nail Care	Dress Patient							
Elastic Hose	Abdominal Binder							
Empty Bag: Type________								
Amount in Bag								
Bed Making	Laundry							
Meal Preparation	Shopping							
Turning	Positioning							
Transfer	Hoyer Lift							
Ambulating / Walker / Cane								
ROM: Upper	Lower							
Exercise: PT / ST / OT								
Condition: Appetite								
Skin								
Pain (Location)								
Anxious / Alert / Confused / Depressed								
Foley Cath	Ostomy							
Incontinent: Urine	Feces							
Bedpan / BS Commode / Bathroom								
AIDE ASSIGNMENT REVIEWED								
EMPLOYEE INITIALS								

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COMMENTS (Include date, problem, name of supervisor notified):

C - Care Given
Y - Yes
X - No Problem

____
Aide Signature

WHITE: CHART YELLOW: COPY

Class Home Health, Inc.

HOME HEALTH HOME CARE AIDE WEEKLY VISIT RECORD

PATIENT NAME: ______________________________ MR: ______________

When completing be sure to follow the Aide Assignment Sheet.

DAY	SUN	MON	TUE	WED	THU	FRI	SAT	WEEK OF
DATE	/ /	/ /	/ /	/ /	/ /	/ /	/ /	___/___/___
TIME IN	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	THROUGH
TIME OUT	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	/ /

	ACTIVITIES	SUN	MON	TUE	WED	THU	FRI	SAT	Comments (All comments must be dated)
BATH	Bath Tub/Shower								
	Bed Bath-Chair								
	Assist Bath-Chair								
HYGIENE/GROOMING	**Personal Care**								
	Assist with Dressing								
	Hair Care-Brush/Shampoo/Other								
	Skin Care/Foot Care (Hygiene)								
	Check Pressure Areas								
	Shave/Groom/Deodorant								
	Nail Hygiene-Clean/File/Report								
	Oral Care-Brush/Swab/Dentures								
	Elimination Assist								
PROCEDURE	Catheter Care								
	Ostomy Care								
	Record Output/Input								
	Inspect/Reinforce Dressing								
	Assist with Medications								
VITAL	Temp-Oral/Axillary/Rectal								
	Pulse-Site and Results								
	Respiration-Results								
	BP-Site and Results								
	Weight-Results								
ACTIVITY	Ambulation Assist-WC/Walker/Cane								
	Mobility Assist								
	ROM-Active/Passive								
	Positioning-Encourage/Assist To Turn q __________ Hrs								
	Exercise-Per PT/OT/SLP Care Plan								
NUTRITIONAL	Diet Order:								
	Meal Preparation								
	Assist with Feeding								
	Limit/Encourage Fluids								
	Grocery Shopping								
	Wash Clothes								
	Light Housekeeping-Bedroom/Bath-room/Kitchen-Change Bed Linen								
OTHER	Equipment Care								

Employee Name: ______________________ ID #: ________ Signature: ______________________

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Total Home Health Care, Inc.

HOME HEALTH AIDE NOTE

M R.# ________________

❑ Chargeable
❑ Non-Chargeable

Pt Sign:______________________ Date: ____________________

PATIENT'S LAST NAME	FIRST NAME		WEEK ENDING:	MONTH	DAY	YEAR

Please, write INITIALS in each visit	AIDE'S INITIAL / PATIENT'S INITIAL							
Check services done on each visit DO NOT do anything that is not in your care plan	DATE ▶	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
PERSONAL CARE ACTIVITIES								
BATH. ❑ Bed ❑ Shower								
Shampoo/Hair Care								
Mouth Care								
Dress								
Shave								
Observe & Report changes in skin								
Special Skin Care								
Nail Care ❑ Fingers ❑ Toes								
Transfer Activity: ❑Hoyer lift ❑Bed to Chair								
Walking cane, walker								
Up with Help								
Foot Care								
Assist with feeding								
Incontinence Care								
Empty Catheter Bag, amount								
Assist, commode, bedpan. urinal, toilet								
Empty ostomy equipment								
Supervision of Self Administration of oral Medications.								
HOUSEHOLD / HYGIENE TASKS								
Prepare and serve meal and/or snack								
Laundry, P.R.N								
Clean Client's Bathroom								
Clean Bedroom								
Clean Kitchen								
Wash Dishes								
Do Groceries								
Make / Change Bed								
VITAL SIGNS								
Temp								
Pulse								
Respirations								
Last Bowel movement:								

OBSERVATIONS:	
SUNDAY	
MONDAY	
TUESDAY	
WEDNESDAY	
THURSDAY	
FRIDAY	
SATURDAY	

I certify that I have performed the activities noted above, honored the patient's rights and utilized Universal Precautions.

I CERTIFY THAT THE HOURS SHOWN REPRESENT MY TOTAL HOURS WORKED DURING THE WEEK AND THAT THEY WERE PROPERLY VERIFIED

AM	✔							
Noon	●							
PM	■							
Night	*							

____
EMPLOYEE NAME

____
EMPLOYEE SIGNATURE

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A&B Home Health, Inc.

HOME HEALTH/HOME CARE AIDE WEEKLY VISIT RECORD

EMPLOYEE NAME ______________________

EMPLOYEE NO. ______________________

When completing be sure to follow the Aide Assignment Sheet

DAY-	SUN	MON	TUE	WED	THU	FRI	SAT	WEEK OF
DATE								/ /
TIME IN:								THROUGH
TIME OUT:								/ /

	ACTIVITIES	SUN	MON	TUE	WED	THU	FRI	SAT	COMMENTS (All comments must be dated)
VITALS	T ____________								
	P ____________								
	R ____________								
BATH	Shower w/ Chair								
	Bed Bath - Partial/Complete								
	Chair Bath								
HYGIENE/GROOMING	Personal Care								
	Assist with Dressing								
	Hair Care								
	Shampoo								
	Skin Care								
	Foot Care								
	Check Pressure Areas								
	Nail Care								
	Oral Care								
	Clean Dentures								
	Other (specify):								
	Assist with Elimination								
	Change Diaper								
	Perineal care								
	Other (specify):								
	Medication Reminder:								
	Other (specify):								
	Ambulation Assist - WC/Walker/Cane								
	Assist with Mobility: Chair Bed/ W/C /Commode/Shower Chair								
	ROM Passive Arm R/L Leg R/L								
	Exercise Per PT/0T Care Plan								
	Other (specify):								
NUTRITION	Meal Preparation								
	Assist with Feeding								
	Grocery Shopping								
OTHER	Wash Clothes								
	Light Housekeeping - Bedroom/Bath-room/Kitchen - Change Bed Linen								
	Make bed								
	Change sheets								
	Companion								
	Escort								
	Respite								
	Homemaker								

SIGNATURES/DATES

Employee ______________________ / / Date ______ Patient/Client ______________________ / / Date

PATIENT/CLIENT NAME Last First Middle Initial MR #

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HOME HEALTH AIDE NOTE

MR# ____________

☐ AM Visit ☐ PM Visit

PATIENT'S LAST NAME FIRST NAME	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
VITAL SIGNS: ☐ Temp / Pulse / Respirations							
BATH: ☐ Shower							
☐ Bed							
☐ BSC							
☐ Shower Chair							
ORAL HYGIENE							
☐ Brush Teeth							
☐ Clean Dentures							
☐ Mouth care							
HAIR CARE							
☐ Comb/Brush Hair							
☐ Shampoo							
NAIL/FOOT CARE							
☐ Nail Cleaning/Filing ☐ Fingers							
☐ Toes							
OTHER							
☐ Shave							
☐ Assist with Dressing							
☐ Skin Care with Lotion							
☐ Catheter Care							
ACTIVITY							
☐ Bed rest							
☐ Turn/Reposition in bed							
☐ Assist with Transfer							
☐ Hoyer Lift							
☐ Assist with Ambulation							
☐ Assistive Device							
☐ Passive ROM Exercises							
ELIMINATION							
☐ Assist with bedpan/urinal							
☐ Assist to bathroom/BSC							
☐ Empty Catheter drainage bag							
☐ Empty colostomy bag							
☐ Last BM ____________							
☐ Perineal Care - Diaper change							
NUTRITION							
☐ Assist with Feedings							
☐ Prepare/Serve Light meal							
☐ Force Fluids							
☐ Restrict Fluids:							
OTHER SERVICES AS PER PT REQUEST							
☐ Change/Straighten bed linen							
☐ Clean/Straighten bedroom/bath area							
☐ Light grocery shopping							
☐ Other: __________________							
☐ Other: __________________							

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Comments: ____

☐ Verified patient's identity prior to start of care (To be done on your first visit)

I CERTIFY THAT THE HOURS SHOWN REPRESENT MY TOTAL HOURS WORKED DURING THE WEEK AND THAT THEY WERE PROPERLY VERIFIED								
	TIME IN ▶							
	TIME OUT ▶							

____________________ Home Health Aide Name (Print)

____________________ Home Health Aide Signature

__________ Title

CORAL HOME CARE, INC.

AIDE ACTIVITY NOTE

Patient Name: ____________________

M.R # ____________________

	SUN	MON	TUES	WED	THUR	FRI	SAT
DATE							
REGULAR VISIT							
REFUSE VISIT							
TIME IN:							
TIME OUT							
Temperature							
Pulse							
Respiration							
Last Elimination Bowel							
Urine							
Bath							
Bed-Complete							
Bed-Partial							
Shower-Standing/Sitting							
Shampoo							
Comb Hair							
Hands							
Oral Hygiene							
Shave							
Skin Care							
Perineal Care							
Nail Care (Do not cut)							
Assist: Turning Patient							
Assist: Transfer Bed/Chair							
Bedridden							
Maintenance of Body Alignment							
Wheelchair							
Ambulate with Assistance							
Ambulate with Cane							
Ambulate with Walker							
Assistance with Dressing							
Bedpan							
Straighten Patient's Area							
Linen Change							
Clean Bathroom							
Clean Kitchen							
Personal Laundry							
Preparation of Meal							
Serving of Meal							
Feed Patient							
Appetite							
Wash Dishes							
Grocery Shopping							
Foley Catheter Care							
Empty Drainage Bag							
Output							
Reinforcement of Dressing							
Assist with Colostomy Care							
Assist with Brace							
(Type)							
Ace Bandage							
Patient Signature							

DATE: COMMENTS:

HHA SIGNATURE____________________ EMPLOYEE NUMBER __________

WITH MY SIGNATURE, I DO CERTIFY THAT THE SERVICES MENTIONED HAVE BEEN PROVIDED BY ME AND THE CLIENT SIGNED THIS DOCUMENT ON MY PRESENCE.

TOTAL HOURS __________

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GALLOWAY
Home Health Care Inc.

HOME HEALTH AIDE NOTE

Patient's Name: ______________________________ HHA Name: ______________________________
Please Print / Please Print

Patient's Number ______________________________ HHA Number ______________________________

DATE OF SERVICES / FECHA DE SERVICIOS							
MENTAL STATUS	SUN	MON	TUE	WED	THU	FRI	SAT
Alert / Alerta							
Oriented/Orientado							
Forgetful / Olvidadizo							
Unresponsive / No **responde**							
BATHING / PERSONAL CARE							
Bed Bath / Baño en cama							
Check Pressure areas / chequear areas de apoyo							
Shower / Ducha / Sitting / Sentado / Standing / De pie							
Mouth Care / Cuidado de la Boca							
Shampoo / Champu / Hair care							
Shave / Afeitar							
Lotion Massage / Masage con Loción							
Nail Care / Cuidado de las Uñas (No clipping)							
Dressing Assistance / Asistir en Vestir **Cliente**							
TRANSFER / AMBULATION							
Transfers Assist / Asistir en Transferir Cliente							
Up in Chair / Sentar en silla / Hoyer Lift / Grua							
Reposition Bed Patient / Reposicionar Paciente en Cama / Bedbound							
Range of Motion / Ejercicios de movimlento							
Ambulate with Assist / Asistencia para ambular/Supervision							
Ambulate with Cane / Walker / Ambular con Bastón / Andador							
NUTRITION							
Meal Preparation / Preparar comida							
Assist with Feeding / Asistir Cliente a Comer							
ELIMINATION							
Client to Toilet / LLevar el Cliente al Inodoro							
Client to Bedside Commode / Cliente al Inodoro Portatil							
Incontinent Care / Diapers / Cuidado de Incontinencia / Pañales							
Urine / Normal / Abnormal							
Last BM / Ultima vez al baño							
HOMEMAKING TASKS							
Laundry / Lavar ropa personal y de cama							
Grocery Shopping Done / Ir al Mercado							
Kitchen / Cocina / Bathroom /Baño/Bedroom/Dormitorio							
Make - Change bed / Hacer - cambiar ropa cama							
T P R							
Temperature							
Pulse							
Respiration							

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DAY	DATE	COMMENTS
SUNDAY		
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
SATURDAY		

I hereby certify that the information contained in this document is true,
and have performed all services in accordance to Agency policy
I certify that I have received no injuries during this assignment.

HHA Signature:
(Firma de asistente) ______________________________

JOOL HOME CARE, INC.

C - Care Given
✓ - Yes
X - No Problem

IN HOME SUPPORT SERVICES

PATIENT ______________________ CR#: ____________

Month 20 ___		Mon		Tues		Wed		Thu		Fri		Sat		Sun	
Bath: Bed	Commode														
Shower	Tub														
Oral Care	Back Rub														
Shampoo	Shave														
Feed Patent	Encourage Fluids														
Nail Care	Dress Patient														
Medical	Dental App.														
Beauty Salon															
Park															
Bed Making	Laundry														
Meal Preparation	Shopping														
Shopping Mall															
Grocery Shopping	Errands														
Ambulating / Walker	Cane														
Medications Pick Up															
Mail Pick Up	Empty Trash														
Cleaning Bedroom															
Clean Bathroom															
Wash Dishes															
Vacuum / Sweep / Dust															
Meeting															
Reading	Math														
Follow Universal Precaution															
A.M.															
P.M.															

MON: ____________ WED: ____________ FRI: ____________

TUES: ____________ THU: ____________ SAT: ____________

SUN: ____________

COMMENTS (Include date, problem, name of supervisor notified):

Aide Signature ______________________

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