# FAMILY GUIDE FOR HOME CARE OF PATIENT

Patient Name _____ Diet _____

Physician Name _____ Phone _____ Next Doctors Appointment _____

Community Agency Contact (VNA, Meals on Wheels, Etc.)

1. Agency Name _____ Contact: _____
   Address _____ Phone: _____
   Date _____ Contacted by: _____

2. Agency Name _____ Contact: _____
   Address _____ Phone: _____
   Date _____ Contacted by: _____

3. Agency Name _____ Contact: _____
   Address _____ Phone: _____
   Date _____ Contacted by: _____

Current Physical Status of Patient: _____

| AMBULATION | Indep. | Assist. | Unable | COMMENTS |
|---|---|---|---|---|
| Bed-to-Chair | | | | |
| Walking | | | | |
| Stairs | | | | |
| Wheelchair | | | | |
| Crutches | | | | |
| Cane | | | | |
| Bed Rest | | | | |

| METHOD OF COMMUNICATION | |
|---|---|
| Verbal | Nonverbal |

| ACTIVITIES | Indep. | Assist. | Unable | COMMENTS |
|---|---|---|---|---|
| Bathes Self | | | | |
| Dresses Self | | | | |
| Feeds Self | | | | |
| Brushes Teeth | | | | |
| Shaves Self | | | | |
| Toilet | | | | |
| Commode | | | | |
| Bed Pan | | | | |
| Urinal | | | | |

Special instructions (medication, dressing changes, injections to be administered, irrigations, etc.):

_____

_____

_____

CURRENT MEDICATIONS AND/OR SPECIAL INSTRUCTIONS

| Medications | Rx # | Quantity | Directions | Special Instructions |
|---|---|---|---|---|
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**The above medications ❑ are ❑ are not in child proof bottles.**

Patient Signature _____ Date _____

Responsible Party _____ Date _____

Nurse Signature _____ Date _____