FAMILY GUIDE FOR HOME CARE OF PATIENT

Patient Name:_____ Diet:_____

Physician Name:_____ Phone:_____ Next Doctors Appointment:_____

Community Agency Contact

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

The above medications ❍ are ❍ are not in child proof bottles.

Patient Signature:_____ Date:_____

Responsible Party:_____ Date:_____

Nurse Signature:_____ Date:_____

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