HOME CARE AIDE CARE PLAN

Patient Address:_____ **Telephone No.**_____

Directions to Home:_____

Case Manager:_____ **Phone No.**_____

Frequency/Duration:_____

Supervisory visits every: ❍ 14 days ❍ 30 days ❍ 60 days ❍ Other_____

Patient problem:

PARAMETERS TO NOTIFY CARE MANAGER

Temp _____ **BP** _____

P _____ **R** _____

Urine_____

Other (pain)_____

DNR: ❍ **Yes** ❍ **No**

PRECAUTIONARY AND OTHER PERTINENT INFORMATION – Mark all that apply.

❑ Lives alone
❑ Lives with other
❑ Alone during the day
❑ Bed bound
❑ Bed rest/BRPs
❑ Up as tolerated
❑ Amputee (specify):

❑ Partial weight bearing: ❍ R ❍ L
❑ Non-weight bearing: ❍ R ❍ L

❑ Fall precautions
❑ Special equipment:

❑ Speech/Communication deficit
❑ Vision deficit: ❑ Glasses
❑ Contacts
❑ Other:_____
❑ Hearing deficit: ❑ Hearing aid
❑ Dentures: ❑ Upper ❑ Lower
❑ Partial

❑ Oriented x 3 ❑ Alert
❑ Forgetful/Confused
❑ Urinary catheter
❑ Prosthesis (specify):

❑ Allergies (specify):

❑ Diabetic ❑ Do not cut nails
❑ Diet:_____
❑ Seizure precautions

❑ Pressure area precautions
❑ Infection precautions:

❑ Bleeding precautions
❑ Watch for ❍ hyper ❍ hypoglycemia
❑ Prone to fractures
❑ Other (specify):

Mark all applicable tasks. Specify by marking the applicable activity for those items.
Write additional precautions, instructions, etc. as needed beside the appropriate item.

	ASSIGNMENT	Every Visit	Weekly	Other – Comments/Instructions
VITALS	Temperature	❍	❍	
	Pulse	❍	❍	
	Respirations	❍	❍	
	Blood Pressure	❍	❍	
	Weight	❍	❍	
	Pain Rating	❍	❍	
BATH	❍ Tub ❍ Shower	❍	❍	
	Bed Bath: ❍ Partial ❍ Complete	❍	❍	
	Assist Bath - Chair	❍	❍	
HYGIENE/GROOMING	Personal Care	❍	❍	
	Assist with Dressing	❍	❍	
	Hair Care	❍	❍	
	Shampoo	❍	❍	
	Skin Care	❍	❍	
	Moisturizer	❍	❍	
	Foot Care	❍	❍	
	Check Pressure Areas	❍	❍	
	Nail Care	❍	❍	
	Oral Care	❍	❍	
	Clean Dentures	❍	❍	
	Shave	❍	❍	
	Other (specify):	❍	❍	
PROCEDURES	Assist with Elimination	❍	❍	
	Catheter Care	❍	❍	
	Ostomy Care	❍	❍	
	Record Intake/Output	❍	❍	
	Inspect/Reinforce Dressing (see specifics in comments)	❍	❍	
	Medication Reminder	❍	❍	
	Medication Assistance	❍	❍	
	Other (specify):	❍	❍	

	ASSIGNMENT	Every Visit	Weekly	Other – Comments/Instructions
ACTIVITY	Assist with: ❑ Ambulation ❑ W/C ❑ Walker ❑ Cane	❍	❍	
	Mobility Assist: ❑ Chair ❑ Bed ❑ Dangle ❑ Commode ❑ Shower ❑ Tub	❍	❍	
	ROM ❑ Active ❑ Passive ❑ Arm: ❑ R ❑ L ❑ Leg: ❑ R ❑ L	❍	❍	
	Positioning - Encourage Assist every ____ hrs	❍	❍	
	Exercise - Per: ❑ PT ❑ OT ❑ SLP Care Plan	❍	❍	
	Other (specify):	❍	❍	
NUTRITION	Meal Preparation	❍	❍	
	Assist with Feeding	❍	❍	
	❍ Limit ❍ Encourage Fluids	❍	❍	
	Grocery Shopping	❍	❍	
	Other (specify):	❍	❍	
OTHER	Wash Clothes	❍	❍	
	Light Housekeeping: ❑ Bedroom ❑ Bathroom ❑ Kitchen ❑ Change Bed Linen	❍	❍	
	Equipment Care	❍	❍	
	Other (specify):	❍	❍	

Signature/Title:_____ Date:_____ Review and/or revise at least every 60 days

SIGNATURE/TITLE	DATE	SIGNATURE/TITLE	DATE

PART 1 - Clinical Record **PART 2 - Patient** **PART 3 - Care Manager**

PATIENT NAME – Last, First, Middle Initial | ID#