Client Service Care Plan

Client Care Plan

OBJECTIVE & DISCHARGE PLAN: TO PROVIDE SUPPORTIVE SERVICES TO MAINTAIN SAFETY, COMFORT, AND INDEPENDENCE. CARE WILL CONTINUE UNTIL SERVICES ARE NO LONGER NEEDED.

Date of Contact

NAME

First Name:		Last Name:
Date of Birth	Gender	Phone:
Advanced Directive: Yes ☐ No ☐	DNR: Yes ☐ No ☐	Medically Frail or Compromised: Yes ☐ No ☐

SERVICE ADDRESS

Line 1		
Line 2		
City	State	Zip Code
Service Hours, Frequency & Duration		
Billing: CCSP ☐ LTC ☐ Private Pay ☐ Source ☐		
Service Type: Personal Care ☐ Companionship ☐ Medical Appointment Only ☐	**Triage/Level of Care:** Can get out on their own ☐ Needs assistance or reminding ☐ Total care or immediate assistance ☐	
Diagnosis / Health Problems:		
Allergies:		
Physician:	Phone:	Hospital:

Client Service Care Plan

Goals of Service
Other Services / Agency in Home
Medication Reminder. If yes, a list and predosed medication is required. Yes ☐ No ☐

Supplemental Oxygen: N/A ☐ Occasional ☐ Continuous ☐ Nasal Cannula ☐

Functional Limitations:

Ambulation ☐	Bedbound ☐	Breathing Problem ☐
Confusion ☐	Hard of Hearing ☐	Incontinence ☐
Legally Blind ☐	Memory ☐	Paralysis ☐
Speech ☐	Weakness ☐	Other ☐

Durable Medical Equipment Used:

Cane ☐	Frame Walker ☐	Rollator ☐
Wheelchair ☐	Gait Belt ☐	Hoyer Lift ☐
Lift Chair ☐	Shower Chair ☐	

Ambulation Precautions:

Contact Guard Assist ☐ High Fall Risk ☐ Unsteady Gait ☐ Stand by Assist ☐

Safeguards:

Cue Activity ☐ Fall Precautions ☐ Swallow Precautions ☐ Hip Precautions ☐

Activity:

No restriction ☐	Up as Tolerated ☐	Bedrest ☐
Reposition ☐	Encourage Legs Raised ☐	Exercise / Walking ☐
Range of Motion ☐	PT Routine ☐	

Recreation: Time Outdoors ☐ Conversation ☐ Memory Games ☐ Books / Pictures / Puzzles ☐

Transportation: Yes ☐ No ☐

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PERSONAL CARE

Bed Bath ☐	Wash up at Sink ☐	Shower ☐
Dressing ☐	Oral Hygiene ☐	Denture Care ☐
Grooming ☐	Clean / File Nails ☐	Clean Eyeglasses ☐
Assist with Hearing Aid ☐	Incontinence Care ☐	Skin Care ☐

Elimination:

Toilet ☐	Incontinence Briefs ☐	Bed-Side Commode ☐
Bed Pan ☐	Empty Catheter Bag ☐	Record BM / Urine Output ☐
Urinal ☐		

NUTRITION / MEAL PREPARATION

Prepare:

Breakfast ☐	Lunch ☐	Dinner ☐
Snack ☐	Small Meal every 3 hours ☐	Nutritional Shake ☐

Encourage Food ☐	Encourage Fluids ☐	Feed Client ☐
Record Intake ☐	Other Diet ☐	Swallow Precautions ☐

Housemaking:

Light Housekeeping ☐	Laundry ☐	Linen Change ☐
Bathroom ☐	Bedroom ☐	Kitchen ☐
Trash ☐	Pet Care ☐	

Special Instructions:

Based on the above comprehensive assessment, is the client considered medically compromised or medically frail? Yes ☐ No ☐

THIS PLAN OF CARE IS REVIEWED AND UPDATED EVERY 60-122 DAYS DURING THE SUPERVISORY VISIT OR AS NEED IS INDICATED BY CLIENT CONDITION.

Care Plan Change? Yes ☐ No ☐	Reason if Supervisory Visit is missed:

X ______________________________
Nurse Name Printed & Date: RN ☐ LPN ☐

X ______________________________
Client or Responsible Party Name Printed

X ______________________________
Nurse Signature

X ______________________________
Client or Responsible Party Signature