

PLAN OF CARE

This Plan of
Care is for: _____

Information Change Date: _____

Care Manager: _____

Type of Worker: _____

Goal of
Service: _____

Personal Information

How to Address Client: _____ DOB _____

Living Arrangement: _____ Family _____

Former Occupation: _____

Directions to home: _____

Pets: _____

Where to Park: _____ Mail: _____

Additional Information: _____ Keys: _____

Medical and Emergency Information

Code Status:_____ Physician:_____

Hospital:_____ Physician Phone:_____

Hospital Phone:_____ Additional Physician:_____

Funeral Home:_____ Additional Physician Phone:_____

Pharmacy:_____ Primary Diagnosis:_____

Pharmacy Phone:_____ Secondary Diagnosis:_____

Physical Health Symptoms:_____ Other Diagnosis:_____

Mental or Cognitive

Symptoms:_____

Who to call in emergency or when health status changes:_____

Other Agency Involved:_____

DUTIES FOR:_____ Care Manager:_____

Information Change Date:_____

Personal Cares

| Done by Client | Needs Assist | Adaptive Devices | Done by Client | Needs Assist | Adaptive Devices |
|----------------------|--------------|------------------|----------------|--------------|------------------|
| Ambulation | | | Medication | | |
| Bathing | | | Oral Care | | |
| Dressing | | | Repositioning | | |
| Feeding | | | Skin Care | | |
| Hair Care | | | Toileting | | |
| Incontinence | | | Transfers | | |
| Special Instructions | | | Vision | | |

IV. **Meal Preparation**

Shopping_____ Breakfast_____

Lunch_____

Special Diet_____ Dinner_____

Snacks_____

Additional Meal Instructions:_____

IV. **Housework** Yes No Frequency/Specific Instructions_____

Bathroom Cleaning_____

Bed Making_____

Dishwashing_____

Dusting_____

Floor Washing_____

Kitchen Cleaning_____

Laundry_____

Linen Changing_____

Trash/Recycling_____

Vacuuming_____

Other Housework_____

Companionship

Yes No Frequency/Specific Instructions

Yes No Frequency/Specific Instructions

Appointments_____ Hairdresser_____

Cards_____ Meals Out_____

Clubs_____ Religious Activities_____

Driving_____ Television_____

Exercise_____ Walking_____

Additional Instructions_____

Scheduled Medication For:_____

Care Manager:_____

Name:_____ Information Change Date:_____

| | MEDICATION | DOSAGE | TIME OF DAY |
|------------------|------------|--------|-------------|
| Medication One | | | |
| Medication Two | | | |
| Medication Three | | | |
| Medication Four | | | |
| Medication Five | | | |
| Medication Six | | | |

Additional Scheduled Medication Instructions: _____

PRN Medication

| | MEDICATION | DOSAGE | TIME OF DAY |
|----------------------|------------|--------|-------------|
| PRN Medication One | | | |
| PRN Medication Two | | | |
| PRN Medication Three | | | |

Additional PRN Medication Instructions: _____

