Home Care Connectors

Home Care Connectors LLC
164 Mason Street
Greenwich CT 06830

Plan Of Care Report

Print Date: Wednesday, June 19, 2019

Client Name: _____ **Client Id:** _____

Address: _____

_____

ABOUT:

HOME PHONE: _____ **BIRTHDAY:** _____ **FIRST LANGUAGE:** _____ **HEIGHT:** _____ **WEIGHT:** _____

AGE: _____

DIET: _____

_____

ALLERGIES: _____

_____

CARE NOTES:

_____

_____

_____

EMERGENCY INSTRUCTIONS:

_____

_____

_____

EMERGENCY CONTACTS:

NAME: _____	**PHONE:** _____	**RELATIONSHIP:** _____
NAME: _____	**PHONE:** _____	**RELATIONSHIP:** _____
NAME: _____	**PHONE:** _____	**RELATIONSHIP:** _____
NAME: _____	**PHONE:** _____	**RELATIONSHIP:** _____
NAME: _____	**PHONE:** _____	**RELATIONSHIP:** _____

MEDICAL PROFESSIONALS:

NAME: _____ **PHONE:** _____ **TYPE:** _____

NAME: _____ **PHONE:** _____ **TYPE:** _____

NAME: _____ **PHONE:** _____ **TYPE:** _____

NAME: _____ **PHONE:** _____ **TYPE:** _____

NAME: _____ **PHONE:** _____ **TYPE:** _____

MEDICATIONS :

MEDICATION	DOSAGE	AMOUNT	ROUTE	FREQUENCY	TIME	GIVEN FOR	PRECAUTIONS	INSTRUCTIONS

PREFERENCES:

- ☐ OK Can work with
- ☐ Needs Training
- ☐ Allergic to Pets
- ☐ Alzheimer & Dementia Experience
- ☐ Artisitc
- ☐ Bathing & Showering Experience
- ☐ Bed Bath Experience
- ☐ Can Cook
- ☐ Car / Driver
- ☐ Cooking Skills
- ☐ Female PCA
- ☐ Hospice Experience
- ☐ Incontinent Experience
- ☐ Caregiver has received lift training to ensure back support and stability.
- ☐ Live in
- ☐ Live out
- ☐ Male PCA
- ☐ Non-Smoker
- ☐ Personality- Outgoing
- ☐ Personality-Quiet
- ☐ Can work Saturdays
- ☐ Smoker
- ☐ Sports Fan
- ☐ Stroke Experience
- ☐ Can work sunday
- ☐ Transferring Experience

DIAGNOSIS:

- ☐ AIDs
- ☐ Alzheimer's
- ☐ Anxiety
- ☐ Arthritis
- ☐ Back Pain
- ☐ Bilateral - Lower Extremeties
- ☐ Bladder Infection
- ☐ Blind
- ☐ Blood Pressure - High
- ☐ Blood Pressure - Low
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Cataracts
- ☐ Circulation Issues
- ☐ Confusion - Extreme
- ☐ Confusion - Mild
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Dialysis
- ☐ Difficulty Swallowing
- ☐ Dizziness
- ☐ Encephalitis
- ☐ Enlarged Prostate
- ☐ Forgetfulness
- ☐ Functional Limitations - Hearing
- ☐ Functional Limitations - Speech
- ☐ Functional Limitations - Vision
- ☐ FX- Ankle (left)
- ☐ FX- Ankle (right)

- [ ] FX- Arm (left)
- [ ] FX- Arm (right)
- [ ] FX- Bone
- [ ] FX- Hip (left)
- [ ] FX- Hip (right)
- [ ] FX- Leg (left)
- [ ] FX- Leg (right)
- [ ] FX- Neck
- [ ] FX- Ribs
- [ ] FX- Wrist (left)
- [ ] FX- Wrist (right)
- [ ] Gall Bladder Issues
- [ ] Glaucoma
- [ ] Hammer Toes
- [ ] Heart Arrhythmia
- [ ] Heart Disease
- [ ] High Blood Sugar
- [ ] High Fall Risk
- [ ] HX - Brain Surgery
- [ ] HX - Fall
- [ ] HX - FX Hip
- [ ] HX - Heart Attack
- [ ] HX - Intestinal Infection
- [ ] HX - Pneumonia
- [ ] HX - Stroke
- [ ] HX - Total Knee Replacement
- [ ] HX - UTI
- [ ] Hypertension
- [ ] IBS
- [ ] Incontinence - Bladder
- [ ] Incontinence - Bowel
- [ ] Kidney Disease
- [ ] Kidney Failure
- [ ] Lung Disease
- [ ] Lung Infection
- [ ] Memory Loss
- [ ] Memory Loss - Long Term
- [ ] Memory Loss - Short Term
- [ ] Multiple Sclerosis
- [ ] Narcoleptic
- [ ] Osteoarthritis
- [ ] Osteoporosis
- [ ] Pain - Moderate - Unspecified Location
- [ ] Pain - Severe - Unspecified Location
- [ ] Pain - Slight - Unspecified Location
- [ ] Paralysis - Left Side
- [ ] Paralysis - Right Side
- [ ] Parkinson's Disease
- [ ] Pulmonary Embolism
- [ ] Pulmonary Fibrosis
- [ ] Renal Failure
- [ ] Schizophrenia
- [ ] Shingles
- [ ] Skin Tears Easily
- [ ] Sleep Apnea
- [ ] Staph Infection
- [ ] Sun Downers
- [ ] Thin or Thinning Skin
- [ ] UTI
- [ ] Water Retention
- [ ] Weakness

SERVICE PLAN:

ADL's

- [ ] Bathing
- [ ] Cooking
- [ ] Doctor Visits
- [ ] Dressing
- [ ] Errands
- [ ] Exercise Assistance
- [ ] Feeding
- [ ] Grooming
- [ ] Hair Care / Shampoo
- [ ] Oral Care
- [ ] Shaving
- [ ] Shopping
- [ ] Shower
- [ ] Skin Care
- [ ] Sponge Bath
- [ ] Transportation
- [ ] Walking

Ambulation

- [ ] Ambulatory / Independent
- [ ] Bed Bound
- [ ] Non-Ambulatory
- [ ] Semi-Ambulatory / Stand By Assist

Caregiver Accommodations

- [ ] Bedroom
- [ ] Meals ARE NOT Provided
- [ ] Meals ARE Provided
- [ ] Private Bath
- [ ] Sofa Bed

Client Condition

- [ ] 1 - Poor
- [ ] 2 - Fair
- [ ] 3 - Good
- [ ] 4 - Excellent

Condition of Home

- [ ] 1 - Poor
- [ ] 2 - Fair
- [ ] 3 - Good
- [ ] 4 - Excellent

Coordinating Organizations

- [ ] Adult Day Care
- [ ] Grant Programs
- [ ] Home Health
- [ ] Hospice

Equipment

- [ ] Commode
- [ ] Elevated Toilet Seat
- [ ] Gait Belt
- [ ] Grab Bars (shower)
- [ ] Grab Bars (tub)
- [ ] Hospital Bed
- [ ] Hoyer Lift
- [ ] Nebulizer Machine

SERVICE PLAN:

- ☐ Oxygen Concentrator
- ☐ Shower Chair
- ☐ Walker / Cane
- ☐ Wheelchair
- ☐ Wheelchair (electric)

Functional Limitations

- ☐ Hearing
- ☐ Speech
- ☐ Vision

Medication Reminders

- ☐ AM Meds (Between 8 am and 10 am)
- ☐ Before Bedtime
- ☐ Before Evening Meal
- ☐ Medications Set Up in Pill Box by Responsible Party
- ☐ Meds 30 Mins Before Breakfast
- ☐ No Medication Reminders
- ☐ PM Meds (Between 7pm & 9pm)

Nutritional Services

- ☐ Encourage Fluids
- ☐ Encourage Fluids
- ☐ Hands on Assist with Feeding
- ☐ Liquid Supplements
- ☐ Low Salt Diet
- ☐ Low Sugar/Carbohydrate Diet
- ☐ Prepare / Plan Breakfast
- ☐ Prepare / Plan Dinner
- ☐ Prepare / Plan Lunch
- ☐ Prepare / Plan Snack
- ☐ Pureed Foods
- ☐ Regular Diet - As Client Prefers
- ☐ Special Diet
- ☐ Thickened Liquids

Personal Interests

- ☐ Movies
- ☐ Music
- ☐ Reading
- ☐ Television

Place of Service

- ☐ Apartment
- ☐ Client Lives Alone
- ☐ Client Lives with Family
- ☐ Condo
- ☐ Facility
- ☐ House
- ☐ Mobile Home

Service Level

- ☐ Level 1 - Low
- ☐ Level 2 - Moderate
- ☐ Level 3 - Difficult

Skin Precautions

- ☐ Apply Lotion Daily to Arms and Legs
- ☐ Easily Bruises
- ☐ Reposition Every (2) Hours Whether in Chair or Bed
- ☐ Skin Tears Easily

Special

- ☐ Hospice
- ☐ Monitor / Observe
- ☐ Pet Care
- ☐ Reposition in Bed

Toileting

- ☐ Bathroom Assist
- ☐ Bedpan
- ☐ Bowel Incontinence
- ☐ Catheter
- ☐ Depends / Briefs
- ☐ Urinal
- ☐ Urinary Incontinence

ASSESSMENT NOTE:

The following information has been provided to and/or discussed with the Client:

_____Roles and Responsibilities _____Code of Ethics _____ Costs & Billing
_____ Confidentiality of Client Information _____Contact Information _____Client Consent
_____ Other: _____Other: _____

Documentation & Information:

I acknowledge that the information and documentation as noted above, has been discussed with me and I will be provided with a copy.

Client Consent:

I consent to have the Non-Medical Home Services as requested and recorded in this Service Plan.

I understand that my service requests/needs will be reviewed by the Supervisor at least every _____ months, or as required, and that the service(s) may be changed according to my needs, wants or wishes.

_____ _____
Assessor Signature: Date

_____ _____
Responsible Party Signature: Date

_____ _____
Client/Client's Representative's Signature: Date

"Caregiver Acknowledgment"

I have read and understand the Care Plan for _____ as of _____. For Questions please call the office at (203) 489-0919. Please Print your name, Sign, and Date the care plan below.

Name	Signature	Date
Name	Signature	Date
Name	Signature	Date
Name	Signature	Date
Name	Signature	Date
Name	Signature	Date
Name	Signature	Date