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 |