AIDE CARE PLAN

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

Directions to Home: _____

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

Frequency/Duration: _____

Supervisory visits: ❑ every 2 weeks ❑ every 30 ❑ every 60 ❑ Other _____

Patient problem: _____

PARAMETERS TO NOTIFY CARE MANAGER

Temp _____ **BP** _____

P _____ **R** _____

Urine _____

Other (pain) _____

DNR: ❑ **Yes** ❑ **No**

PRECAUTIONARY AND OTHER PERTINENT INFORMATION – Check all that apply. Circle the appropriate item if separated by slash.

- ❑ 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 precaution
- ❑ Watch for hyper/hypoglycemia
- ❑ Bleeding precautions
- ❑ Prone to fractures
- ❑ Other (specify): _____
- ❑ _____
- ❑ _____

Check all applicable tasks. Specify by circling the applicable activity for those items separated by slashes. 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	❑	❑	
	Foot Care	❑	❑	
	Check Pressure Areas	❑	❑	
	Nail Care	❑	❑	
	Oral Care	❑	❑	
	Clean Dentures	❑	❑	
	Other (specify): _____	❑	❑	
PROCEDURES	Assist with Elimination	❑	❑	
	Catheter Care	❑	❑	
	Ostomy Care	❑	❑	
	Record Intake/Output	❑	❑	
	Inspect/Reinforce Dressing (see specifics in comment section)	❑	❑	
	Medication Reminder	❑	❑	
	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#