HOME HEALTH AIDE CARE PLAN

PATIENT NAME ____________________________________ EPISODE PERIOD________________
Start of Care ____________________________________ DOB ___________________________
Diagnosis/Problem ____
Address ____________________________________ Phone__________________________

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Home Health Aide Visit Frequency

Specific Week to Start:_______________

❑ DNR (Do Not Resuscitate)
❑ Allergy____________________
❑ Patient/Cg Accepted the Aide Care

Disciplines Involve in Care: ❑ SN ❑ PT ❑ OT ❑ ST ❑ Aide ❑ MSW ❑ Dietitian
Living Situation: ❑ Alone ❑ Lives with ____________________________
Mentation: ❑ Alert ❑ Oriented ❑ Disoriented _______ ❑ Sleepy/Lethargic ❑ Unresponsive
Sensory Deficits: ❑ Vision ❑ Hearing ❑ Speech ❑ Others_________
Mobility: ❑Up as Tol (FWB/PWB/NWB - R/L) ❑ Chair Bound ❑ Bed Bound ❑ Bed Rest ❑ Bathroom Privileges ❑ Amputee (Location) ________
DME Used: ❑ Cane ❑ Walker ❑ Wheelchair ❑ Oxygen ❑ Prosthesis (Specify) ___________
Appliance Used: ❑ Foley Catheter ❑ Suprapubic Catheter ❑ Ostomy _______________ ❑ Others_________
Precautions: ❑ Hip ❑ Seizure ❑ Diabetes ❑ Bleeding ❑ Infection Control ❑ Oxygen ❑ Others_________

Parameters to Notify the Case Manager:
Temperature: Less Than ___________ More Than _____________
Pulse Rate: Less Than ___________ More Than _____________
Pain: More Than _____________
Weight: Less Than ___________ More Than _____________
Respiratory Rate: Less Than ___________ More Than _____________
Blood Pressure: Less Than ___________ More Than _____________
Other: ____

VITALS	Every Visit	Every Week
Temperature: Oral/Axilla/Rectal/Temporal Scan		
Pulse		
Respiratory		
Blood Pressure: Right Arm/ Left Arm		
Weight		
Pain (Using Pain Scale of 1-10)		
PERSONAL CARE AND GROOMING	**Every Visit**	**Every Week**
What is the Primary Bath Ordered: **Circle ONE:** Tub Shower Bed Bath - Complete Bed Bath - Partial Sponge/Chair Bath Comments:		
Shampoo		
Perineal Care		
Assist with Dressing		
Hair Care: Brush		
Skin Care: Apply Lotion ❑ Report Breakdown		
Shave ❑ Electric Razor Only		
Nail Care ❑ Diabetic: Do Not Cut Nails		
Oral Hygiene		
Denture Care		
Foot Care		
Other:		

Review Date/Signature:

Remarks:

ACTIVITY	Every Visit	Every Week
Assist in Ambulation ❑ WC ❑ Walker ❑ Cane		
Assist in Transfer & Mobility ❑ Chair ❑ Bed ❑ BR		
ROM - Active		
ROM - Passive		
Encourage Positioning/Turning		
Exercise - Per PT/OT/SLP Care Plan		
NUTRITION	**Every Visit**	**Every Week**
Meal Preparation Diet:________________		
Assist with Feeding		
Fluids - Limit (Specify)		
Fluids - Encourage (Specify)		
Measure and Record Intake and Output		
OTHER	**Every Visit**	**Every Week**
Assist with Elimination (Bedpan/Urinal/Commode)		
Catheter Care (Condom/Foley/Suprapubic)		
Colostomy Care		
Reinforce Wound Dressings		
Change Bed Linen		
Light Housekeeping - Bedroom/ Bathroom/ Kitchen		
Wash Patient's Dishes/Laundry		
Medication Reminders		
Equipment Care		
Other:		
Other:		

Review Date/Signature:

Remarks:

Case Manager/Title: Date:

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(White Copy- Office ; Yellow Copy- Patient; Pink Copy- Clinician)