TOTAL CARE HOME HEALTH AGENCY

Aide Care Plan

Name of Patient/Client: □ Male □ Female Age:_____

Goals of Care: □ Patient will be free from injury □ Patient will receive assistance with ADLs/IADLs

□ Other:_____

(Check appropriate interventions, write specifics as needed)

Nutrition □ Type of Diet_____ □ Plan/Prepare Meals/Snacks □ Serve Meals
□ Assist with Eating □ Offer Fluids □ Fluid Restriction □ Thicken Fluids

Body Mechanics/Mobility

Transfer: □ Assist □ Stand/Pivot □ Sliding Board □ Bedrest □ Hoyer

Ambulation: □ Assist □ Cane □ Wheelchair □ Walker □ Crutches
□ ROM/HEP □ Apply Orthopedic Device
□ Other _____

Personal Care/Assistance with ADLs

Bathing: □ Tub □ Shower □ Bed □ Chair □ Shower Bench
□ Hand Held Shower □ Other _____

Hair: □ Comb/Brush □ Shampoo □ Condition

General: □ Dress □ Shave □ Skin Care/Grooming_____

Oral Hygiene: □ Clean Dentures □ Brush Teeth □ Mouthwash □ Oral Swabs

Toileting: □ Assist to Commode/Toilet □ Assist with Bedpan/Urinal □ Catheter Care
□ Empty Catheter/Drainage Bag □ Diapers/Depends □ Other_____

Homemaking: □ Shop □ Straighten □ Clean Bathroom after use □ Clean Kitchen after Meal Prep
□ Make Bed □ Change Bed Linen □ Personal Laundry □ Medication Reminder Assistance
□ Other _____

Other/Record: □ TempA/O □ Intake/Output □ Pulse □ B/P □ Respiration □ Observe Universal Precautions
*Call office immediately for any fall, loss of consciousness, injury, oral temp above___ __, pulse above___ or below_*

Safety Instructions:_____

Infection Control Instructions:_____

Special Instructions:	Dates:	Reviewed By:	For Period:
Other: _____			

Prepared By:Date:_____