

SUNSHINE GOOD CARE, LLC

HOME HEALTH AIDE ASSIGNMENT SHEET/ CARE PLAN

PATIENT NAME: _____ MED. REC. # _____ DATE: _____

DX: _____ FREQUENCY: _____

DIRECTIONS / SPECIAL ARRANGEMENTS: _____

PERSONAL ASSISTANCE REQUIRED

FIRST VISIT	SECOND VISIT	THIRD VISIT	FOURTH VISIT
Tub Bath [] total [] assist	Tub Bath [] total [] assist	Tub Bath [] total [] assist	Tub Bath [] total [] assist
Shower [] total [] assist	Shower [] total [] assist	Shower [] total [] assist	Shower [] total [] assist
Sponge bath [] total [] assist	Sponge bath [] total [] assist	Sponge bath [] total [] assist	Sponge bath [] total [] assist
Bed Bath [] complete [] partial	Bed Bath [] complete [] partial	Bed Bath [] complete [] partial	Bed Bath [] complete [] partial
Shampoo, prn [] total [] assist	Nail Care, prn	Nail Care, prn	Nail Care, prn
Hair Care	Skin Care, prn	Skin Care, prn	Skin Care, prn
Shave, prn	Foot Care, prn	Foot Care, prn	Foot Care, prn
Nail Care, prn	Perineal Care, prn	Perineal Care, prn	Perineal Care, prn
Skin Care, prn	Check Pressure Areas	Check Pressure Areas	Check Pressure Areas
Foot Care, prn	Dentures Care	Dentures Care	Mouth Care: [] Oral [] Dentures
Perineal Care, prn	Assist with Toileting	Assist with Toileting	Assist with Toileting
Check Pressure Areas	Foley Care: [] Empty [] Change	Foley Care: [] Empty [] Change	Foley Care: [] Empty [] Change
Mouth Care: [] Oral [] Dentures	Ostomy Care	Ostomy Care	Ostomy Care
Assist with Dressing	Diaper Change, prn	Diaper Change, prn	Diaper Change, prn
Assist with Toileting	Medication Reminder, prn	Medication Reminder, prn	Medication Reminder, prn
Foley Care: [] Empty [] Change	Assist with Ambulation	Assist with Ambulation	Assist with Ambulation
Ostomy Care	Assist with Transfers	Assist with Transfers	Assist with Transfers
Diaper Change, prn	Transfer Bed/Chair, pro	Transfer Bed/Chair, prn	Transfer Bed/Chair, prn
Medication Reminder, prn	Repositioning [] Q2 hrs [] Prn	Repositioning [] Q2 hrs [] Prn	Repositioning [] Q2 hrs [] Prn
T.P.R.	R.O.M. [] Active [] Passive	R.O.M. [] Active [] Passive	R.O.M. [] Active [] Passive
Assist w/[] Ambulation [] Transfers	Assist with Feeding	Assist with Feeding	Assist with Feeding
Transfer Bed/Chair, prn	Meal Preparation	Meal Preparation	Meal Preparation
Repositioning [] Q2 hrs [] Prn	Light Shopping, prn	Light Shopping, prn	Light Shopping, prn
R.O.M. [] Active [] Passive	Light Personal Laundry, prn	Light Personal Laundry, prn	Light Personal Laundry, prn
Assist with Feeding	Tidy up Bedroom	Tidy up Bedroom	Tidy up Bedroom
Meal Preparation	Tidy up Bathroom	Tidy up Bathroom	Tidy up Bathroom
Light Shopping, prn	Tidy up Kitchen	Tidy up Kitchen	Tidy up Kitchen
Light Personal Laundry, prn	Tidy up Bathroom	Tidy up Bathroom	Tidy up Bathroom
Tidy up Bedroom	Make Bed	Make Bed	Make Bed
Tidy up Bathroom	Change Linens, prn	Change Linens, pro	Change Linens, prn
Tidy up Kitchen			
Make Bed			
Change Linens, prn			

EQUIPMENT USE

- WHEELCHAIR HOSP. BED SHOWER CHAIR WALKER CANE
 HOYER LIFT OTHER _____

FUNCTIONAL LIMITATIONS

- VISION (GLASSES, ETC..) LEGALLY BLIND PARALYSIS HARD OF HEARING
 SPEECH BOWEL INCONTINENCE BLADDER INCONTINENCE AMBULATION
 DYSPNEA W/MIN EXERTION ENDURANCE CONTRACTURE AMPUTATION

PARAMETERS FOR CARE MANAGER NOTIFICATION

VITAL SIGN RANGES

TEMP _____ PULSE _____ RESP _____ WEIGHT _____

SIGNS/SYMPTOMS TO REPORT TO RN _____

SPECIAL PRECAUTIONS _____

- SAFETY PRECAUTIONS Universal Cardio/Pulmonary Respiratory Wound Skin Breakdown Oxygen
 Aspiration Diabetic Bleeding Seizure Fall Infection Control Catheter 911 Protocol

NURSE SIGNATURE: _____ DATE _____

PATIENT SIGNATURE: _____ DATE _____



Name: _____ Pt. #: _____ Dx: _____

<i>Personal Care</i>		<i>Nutrition</i>		<i>Elimination</i>		<i>Activity</i>	
	Bed Bath		Diet		Check BM each visit & chart		Complete bed rest
	Complete		Fluids		Bedpan		OOB in wheelchair
	Partial		Limit		Bedside commode,		OOB whit assist
	Tub Bath		Force		Bathroom		Walking
	Shower,		Prepare meal		I&O		Turns & position
	Shave		Serve meal		Empty drain bag		Side rails
	Shampoo		Feed patient		Chart amount		Range of motion
	Comb Hair		Wash dishes		S & A (urine)		Assist with walker
	Oral Hygiene				Ass't pt. to test urine		Crutches
	Nails (do not cut toenails)				Catheter care		
	TPR (Each visit)				Peri-Care		
	Check oral meds & freq.						

Other _____

Chart any change in ADL status daily. Notify SN of any changes

RN Signature _____ Date: _____

Print Name _____ Print Title: _____

Legend: I = Independent A = Assist

HHA / HOMEMAKER CARE PLAN

Home Health Aide Homemaker

Patient Name _____ Patient # _____ Date of First Visit _____

Supervisor _____ HHA Frequency _____ Caregiver Name _____

Diagnosis/Patient Problems _____

Address _____ Phone _____ Date of Birth _____

Directions _____

ASSIGNMENTS: Specify Q/Visit, frequency with day of week, at patient request or PRN.

VITAL SIGNS		FREQUENCY							TOTAL SUPPORT	ASSIST	SELF CARE	FREQUENCY
Temperature					SKIN CARE				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BP					ACTIVITY				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pulse					Ambulation Assist				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Respiration					Walker/Wheelchair				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					Mobility Assist				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					Chair/Bed				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					Dangle/Commode				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					Exercise per PT/OT CP				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					Reposition Patient				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BATH					MEALS							
Bed/Tub/Shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Prepare				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bed- Partial/Complete	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Feed				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Assist Bath-Chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Setup				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shampoo Hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Offer Oral Supplement				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Comb Hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		HOUSEKEEPING							
Mouth Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Change Bed Linens				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shave <input type="checkbox"/> Electr. <input type="checkbox"/> Straight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Make Bed				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Assist with Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Straighten Room				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					Laundry				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					Shopping				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HAND / FOOT CARE												
Clean/File Nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Soak Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
ELIMINATION												
Perineal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
External Cath Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Measure Cath Output	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Empty Drainage Bag	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									

DO CPR DO NOT DO CPR

PERTINENT INFORMATION

- Lives Alone
- Lives with other: _____
- Alone during the day
- Bed Bound Bed Rest/BRP's
- Up us tolerated
- Amputee (specify) _____
- Partial weight bearing: Right Left
- Non-weight bearing: Right Left
- Hip precautions
- Prone to fractures
- Prosthesis (specify): _____
- Special Equipment: _____
- Speech/Communication deficit
- Vision deficit Glasses
- Contacts Other _____
- Hearing deficit Hearing Aid
- Dentures: Upper Lower Partial
- Oriented x 3 Alert
- Forgetful/Contused
- Diabetic
- Diet _____
- Seizure precautions
- Bleeding precaution
- Pain Medication
- O2
- Allergies (specify) _____

SAFETY

- Fall Precautions
- 24* Supervision
- Emergency Call System
- Other: _____

Other (specify): _____

Special Instructions: _____

Parameters, or Special Conditions, to Report to Nurse:

Review Date / Initials	Review Date / Initials	Review Date / Initials	Review Date / Initials
Nurse's /Therapist's Signature			Date

Chinny Nurses Registry

HOME HEALTH AIDE CARE PLAN

Client Name: _____ **M.R. #:** _____ **Date:** _____
Address: _____ **Phone:** _____
Diagnosis: _____ **Diet:** _____ **Allergies:** _____

Functional status: <input type="checkbox"/> alert <input type="checkbox"/> forgetful <input type="checkbox"/> disoriented <input type="checkbox"/> depressed <input type="checkbox"/> agitated <input type="checkbox"/> blind <input type="checkbox"/> vision impaired <input type="checkbox"/> HOH <input type="checkbox"/> deaf <input type="checkbox"/> Speech/language <input type="checkbox"/> unsteady gait <input type="checkbox"/> fall risk <input type="checkbox"/> seizures <input type="checkbox"/> Diabetes <input type="checkbox"/> Cardiac <input type="checkbox"/> Oxygen <input type="checkbox"/> other: _____
Safety measures: <input checked="" type="checkbox"/> universal precautions <input checked="" type="checkbox"/> maintain safe environment <input checked="" type="checkbox"/> other: _____

Problems / needs:
 Mobility
 Environment
 Nutrition/Hydration
 Housekeeping
 Safety
 Personal Care
 ADL
 Skin Integrity
 Incontinent Bladder
 Incontinent Bowel
 Other: _____

- Goals:**
- Client's personal care/ADL needs will be met.
 - Client's safe environment will be maintained
 - Client/S.O. will be independent in personal care/ADL
 - Client's nutrition/hydration needs will be met
 - Client's skin integrity will be maintained
 - Client will avoid accidents/injury.

Action/Task	Check (all that apply)	Action/Task	Check (all that apply)
Take and record TPR		Note client voiding	
Bed sponge bath		Note BM	
Shower		Catheter/Ostomy care	
Shave		Assist with Ambulation	
Skin care / Back rub		Assistive devices	
Oral Hygiene		<input type="checkbox"/> W/C <input type="checkbox"/> cane <input type="checkbox"/> Walker	
Comb / style hair		Assist with Transfers	
Shampoo hair		<input type="checkbox"/> Hoyer <input type="checkbox"/> belt <input type="checkbox"/> stand-by	
Dress client		Turn and Position every 2 hours	
Assist client dressing		Make bed/Care of sick room	
Feed client		Change lines weekly and PRN	
Assist with meal		Light housekeeping	
Encourage fluids		Grocery shopping	
Assist to bathroom/BSC		Client's laundry	
Offer bedpan / urinal		Prepare meals	

Notify SN of the following:

T above _____ bellow _____
P above _____ below _____
R above _____ below _____

Elimination: pain, discomfort or blood in stool
 Urine: cloudy, concentrated, visible sediment,
 difficult urination, catheter: clogged or leaking
Skin: reddened, dry, cracked, bruised, itching,
 discharge or bleeding.
Nutrition: change in appetite, fluid intake,
 Non-compliance with diet/fluid orders.

Activity: change in client's level of ability, weakness, unsteady gait, of any falls.

Environmental: frayed wires, scatter rugs, inadequate lighting, no phone, lack or malfunction of necessary equipment.

Psychosocial: change in behavior, level of orientation of emotional status.

R.N. Signature	Date	RN Signature	Date

HOME HEALTH AIDE CARE PLAN

PATIENT NAME (Last, First)	PATIENT #	SOC / RI DATE	TYPE OF DIAGNOSIS

PERTINENT PATIENT INFORMATION/SPECIAL INSTRUCTIONS DO NOT RESUCITATE ORDER []

CAREGIVER(S) _____
 ALLERGIES: _____
 DIET: _____

PERSONAL CARE
<input type="checkbox"/> Bed Bath
<input type="checkbox"/> Shower Sit/ Stand
<input type="checkbox"/> Bath Supervision
<input type="checkbox"/> Hair Care / Shampoo
<input type="checkbox"/> Oral care
<input type="checkbox"/> Nail Care (Do Not Cut)
<input type="checkbox"/> Pen Care
<input type="checkbox"/> Skin Care
<input type="checkbox"/> Shave
<input type="checkbox"/> Dress
<input type="checkbox"/> Teds/Ace Application
<input type="checkbox"/> Assist w/ Toileting
<input type="checkbox"/> Feeding
<input type="checkbox"/> Linen Change
<input type="checkbox"/> Assist in Ambulation
<input type="checkbox"/> Transfer Bed-Chair
<input type="checkbox"/> Foley Catheter (cc)

HOMEMAKER
<input type="checkbox"/> Light Cleaning
<input type="checkbox"/> Laundry
<input type="checkbox"/> Shopping / Errands
<input type="checkbox"/> Meal Preparation
<input type="checkbox"/> Wash Dishes

COMPANIONSHIP
<input type="checkbox"/> Companionship

RESPIRE
<input type="checkbox"/> Respite

MONITOR VITAL SIGNS
<input type="checkbox"/> Temperature
<input type="checkbox"/> Pulse
<input type="checkbox"/> Respiration

PROBLEM
SELF CARE DEFICIT RELATED TO:
<input type="checkbox"/> General weakness
<input type="checkbox"/> Paralysis
<input type="checkbox"/> Amputation
<input type="checkbox"/> Recent surgery
<input type="checkbox"/> Debilitating disease
<input type="checkbox"/> Confusion
<input type="checkbox"/> Immobility
<input type="checkbox"/> Bedridden
<input type="checkbox"/> Cast
<input type="checkbox"/> Assistive device(s)
<input type="checkbox"/> Wheelchair
<input type="checkbox"/> Walker
<input type="checkbox"/> Cane
<input type="checkbox"/> Quadcane
<input type="checkbox"/> Braces
<input type="checkbox"/> Sensory Deficit
<input type="checkbox"/> Blind/poor vision
<input type="checkbox"/> Deaf/HOH

PROGNOSIS
<input type="checkbox"/> Excellent
<input type="checkbox"/> Good
<input type="checkbox"/> Fair
<input type="checkbox"/> Poor
<input type="checkbox"/> Guarded

COPING
<input type="checkbox"/> Unable to Perform Self Task
<input type="checkbox"/> Able to Assist
<input type="checkbox"/> Other

PRECAUTIONS
<input type="checkbox"/> Seizures <input type="checkbox"/> Oxygen <input type="checkbox"/> Safety _____ <input type="checkbox"/> Weight Bearing Limitation _____ <input type="checkbox"/> Fluid Restriction _____ <input type="checkbox"/> Activities Not Permitted _____

SIGNATURE OF NURSE	DATE



Patient Address: _____ Telephone No. _____

Directions to Home: _____

Goals for care: Effective and safe personal care. Patient/Client clean and comfortable.
 Other (specify): _____

Frequency/Duration: _____

Supervisory visits: q 14 days q 60 days Other _____

Patient problem: _____

PARAMETERS TO NOTIFY CARE MANAGER

T' > 99.8 BP < 100/60 > 146/96

p < 60 or > 110 R < 16 or > 22

Urine Foul odor, cloudy, blood tinged

Other (pain) Severe without relief

DNR: Yes No N/A

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

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Lives alone
<input type="checkbox"/> Lives with other
<input type="checkbox"/> Alone during the day
<input type="checkbox"/> Bed bound
<input type="checkbox"/> Bed rest/BRPs
<input type="checkbox"/> Up as tolerated
<input type="checkbox"/> Amputee (specify): _____
<input type="checkbox"/> Partial weight bearing: <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Non weight bearing: <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Fall precautions
<input type="checkbox"/> Special equipment: _____
<input type="checkbox"/> Speech/Communication deficit
<input type="checkbox"/> Vision deficit: <input type="checkbox"/> Glasses
<input type="checkbox"/> Contacts
<input type="checkbox"/> Other: _____
<input type="checkbox"/> Hearing deficit: <input type="checkbox"/> Hearing aid | <input type="checkbox"/> Dentures: <input type="checkbox"/> Upper <input type="checkbox"/> Lower
<input type="checkbox"/> Partial
<input type="checkbox"/> Oriented x 3 <input type="checkbox"/> Alert
<input type="checkbox"/> Forgetful/Confused
<input type="checkbox"/> Urinary catheter
<input type="checkbox"/> Prosthesis (specify): _____
<input type="checkbox"/> Allergies (specify): _____ | <input type="checkbox"/> Diabetic <input type="checkbox"/> Do not cut nails
<input type="checkbox"/> Diet: _____
<input type="checkbox"/> Seizure precaution
<input type="checkbox"/> Watch for hyper/hypoglycemia
<input type="checkbox"/> Bleeding precautions
<input type="checkbox"/> Prone to fractures
<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> _____ |
|---|--|---|--|

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		ASSIGNMENT	Every visit	Weekly	Other - Comments/Instructions
	Temperature	<input type="checkbox"/>	<input type="checkbox"/>			Assist with Ambulation W/C / Walker / Cane	<input type="checkbox"/>	<input type="checkbox"/>	
	Pulse	<input type="checkbox"/>	<input type="checkbox"/>			Assist with Mobility Chair / Bed / Dangle Dangle / Commode Shower / Tub	<input type="checkbox"/>	<input type="checkbox"/>	
	Respirations	<input type="checkbox"/>	<input type="checkbox"/>			ROM Active / Passive Arm R/L Leg R/L	<input type="checkbox"/>	<input type="checkbox"/>	
	Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			Positioning - Encourage Assist _____ hrs	<input type="checkbox"/>	<input type="checkbox"/>	
	Weight	<input type="checkbox"/>	<input type="checkbox"/>			Exercise - Per PT / OT / SLP Care Plan	<input type="checkbox"/>	<input type="checkbox"/>	
	Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>			Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	
	Tub/Shower	<input type="checkbox"/>	<input type="checkbox"/>			Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	
	Bed Bath - Partial/Complete	<input type="checkbox"/>	<input type="checkbox"/>			Assist with Feeding	<input type="checkbox"/>	<input type="checkbox"/>	
	Assist Bath - Chair	<input type="checkbox"/>	<input type="checkbox"/>			Limit/Encourage Fluids	<input type="checkbox"/>	<input type="checkbox"/>	
	Personal Care	<input type="checkbox"/>	<input type="checkbox"/>			Grocery Shopping	<input type="checkbox"/>	<input type="checkbox"/>	
	Assist with Dressing	<input type="checkbox"/>	<input type="checkbox"/>			Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	
	Hair Care	<input type="checkbox"/>	<input type="checkbox"/>			Wash Clothes	<input type="checkbox"/>	<input type="checkbox"/>	
	Shampoo	<input type="checkbox"/>	<input type="checkbox"/>			Light Housekeeping Bedroom / Bathroom / Kitchen / Change Bed Linen	<input type="checkbox"/>	<input type="checkbox"/>	
	Skin Care	<input type="checkbox"/>	<input type="checkbox"/>			Equipment Care	<input type="checkbox"/>	<input type="checkbox"/>	
	Foot Care	<input type="checkbox"/>	<input type="checkbox"/>			Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	
	Check Pressure Areas	<input type="checkbox"/>	<input type="checkbox"/>						
	Nail Care	<input type="checkbox"/>	<input type="checkbox"/>						
	Oral Care	<input type="checkbox"/>	<input type="checkbox"/>						
	Clean Dentures	<input type="checkbox"/>	<input type="checkbox"/>						
	Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>						
	Assist with Elimination	<input type="checkbox"/>	<input type="checkbox"/>						
	Catheter Care	<input type="checkbox"/>	<input type="checkbox"/>						
	Ostomy Care	<input type="checkbox"/>	<input type="checkbox"/>						
	Record Intake/Output	<input type="checkbox"/>	<input type="checkbox"/>						
	Inspect/ Reinforce Dressing (see specifics in comment section)	<input type="checkbox"/>	<input type="checkbox"/>						
	Medication Reminder	<input type="checkbox"/>	<input type="checkbox"/>						
	Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>						

RN Signature/Title: _____ Date: _____ Review and/or revise at least every 60 days

Review/Revise SIGNATURE/TITLE	DATE	Review/Revise SIGNATURE/TITLE	DATE
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PART 1 - Clinical Record

PART 2 - Patient

PATIENT NAME - Last, First, Middle Initial

MR #



AIDE ASSIGNMENT/TAREAS DE LA ASISTENTE DE ENFERMERA

PATIENT NAME (Last, First) <i>Nombre del Paciente</i>	MR#	SOC DATE/Fecha de Inicio	TYPE OF DIAGNOSIS/Diagnóstico
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Vive solo, sordo, ciego, olvidadizo, _____ *Lado débil, Dieta*
 Lives alone, deaf, blind, forgetful, _____ sided weakness, Diet _____
 Pl. Care Supervisor _____, Care Team Nurse, PT, ST, OT, Social Worker, Dietician
Supervisor

PRECAUCIONES: *Convulsiones* *Limitaciones de Peso* *Retención de Fluido*
PRECAUTIONS Seizure Weight bearing limitations _____ Fluid restriction _____
 Oxygen Activities not permitted _____ Safety _____
Oxigeno *Actividades no permitidas* *Seguridad*

OBSERVE, RECORD and REPORT CHANGES *OBSERVE y REPORTE CAMBIOS*
 Temperature/Temperatura Skin Condition/Condición de la piel Last BM/Ultima vez al baño
 pulse/pulso Mood/Attitude/Temperamento Actitud Intake and Output/Liquidos Tomados y Salidas
 Respiration/Respiración Pain/Dolor Urine in bag-amount and color/Orine en bolsa, cantidad y color
 Appetite/Apetito Swelling/Sudoración Ostomy bag contents-amount and type/Bolsa de Ostomia

PERSONAL CARE *CUIDADO PERSONA*
 Bed bath/Baño en cama Brush/comb hair/Cuidado del pelo Skin care with lotion/Cuidado de la piel con loción
 Commode bath/Baño con asistencia Oral care/Cuidado bucal Back rub with lotion/Masaje espalda con loción
 Tub bath with seat/Baño con silla Clean dentures/Limpiar dentaduras Foot care-clean, dry, inspect/cuidado de los pies. inspección
 Shower with assist/Ducha con asistencia Clean, file nails/cuidar uñas(no cortar) Perineal care/Cuidado area perianal
 Shampoo Shave/Afeitar Catheter care/Cuidado de las sondas

ELIMINATION *ELIMINACION*
 Assist with *Asistir con:* **Empty/Vaciar** **Change/Cambiar**
 Bed pan/cuña Urine bag/Bolsa de Orine Urine night or leg bag/Bolsa del pie de Orine
 Bedside commode/Silla comodín Commode bucket/Recipiente del Comodín Diapers/Pampers
 House bathroom/Baño de la casa Ostomy bag/Bolsa de Ostomia Underpad/Ropa interior

ACTIVITY *ACTIVIDADES*
 Bedrest/Descanso en cama Trasfer to chair/Transferirse a la silla Walk independent with standby/Camina independiente
 Turn/reposition in bed/Mover-posicion en cama 1 person assist/Asistencia de 1 persona Walk with assist/Camina con asistencia
 Side rails up/Agarraderas 2 person assist/asistencia de 2 personas Walker/Burrito
 Dangle Hoyer lift/Grua Cane/Bastón
 Passive ROM/movimientos pasivos _____ 1 person/persona
 Exercises as Therapist taught/Ejercicios 2 persons/personas

ADL Dress patient/Vestir al paciente Clean and Straighten/Limpiar Change bed each visit/Cambiar cama cada visita
 Assist Dress patient/Ayudar a vestir Bedroom/Cuartos Change bed PRN/Cambias cama si es necesario
 Bedside commode/Silla comodín Bath area/Baños Shopping/Compras
 Kitchen if used/Cocina si es usada Laundry/Lavar ropa

NUTRITION Encourage fluids/Reenforzar líquidos Prepare and serve meal PRN/Preparar comida
 Check foods available/Chequear comida disponible Assist with feeding as needed PRN/Alimentar

Additional information: _____
 Información Adicional: _____

SIGNATURE/FIRMA OF RN ORIGINATOR: _____

DATE/Fecha	CHANGES / REVIEWED PLAN/Cambios	SIGNATURE/Firma

HOME HEALTH/HOME CARE AIDE ASSIGNMENT SHEET

Care Manager _____ Phone No. _____ Frequency/Duration: Aide visits _____ Super. visits _____ Patient/Client problem: _____ Goals for care: <input type="checkbox"/> Effective and safe personal care <input type="checkbox"/> Patient/Client clean, comfortable <input type="checkbox"/> Other (specify) _____	PARAMETERS TO NOTIFY CARE MANAGER T _____ BP _____ P _____ R _____ Urine _____ Other (pain) _____
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PRECAUTIONARY AND OTHER PERTINENT INFORMATION-Check all that apply. Circle the appropriate item if separated by slash.

Patient/Client Address: _____ Telephone No. _____
 Directions to Home" _____

<input type="checkbox"/> Lives alone <input type="checkbox"/> Lives, with other <input type="checkbox"/> Alone during the day <input type="checkbox"/> Bed bound <input type="checkbox"/> Bed rest/BRPs <input type="checkbox"/> Up as tolerated <input type="checkbox"/> Amputee (Specify) _____ <input type="checkbox"/> Partial weight bearing <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Non weight bearing <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Hip precautions <input type="checkbox"/> Special equipment _____	<input type="checkbox"/> Speech/Communication deficit <input type="checkbox"/> Vision deficit: <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Other _____ <input type="checkbox"/> Hearing deficit: <input type="checkbox"/> Hearing aid <input type="checkbox"/> Dentures <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Partial <input type="checkbox"/> Oriented x 3 <input type="checkbox"/> Alert <input type="checkbox"/> Forgetful/Confused <input type="checkbox"/> Urinary catheter <input type="checkbox"/> Prosthesis (specify) _____ <input type="checkbox"/> Allergies (specify) _____	<input type="checkbox"/> Diabetic <input type="checkbox"/> Do not cut nails. <input type="checkbox"/> Diet _____ <input type="checkbox"/> Seizure precaution <input type="checkbox"/> DNR <input type="checkbox"/> Watch for hyper/hypoglycemia <input type="checkbox"/> Bleeding Precautions <input type="checkbox"/> Prone to fractures <input type="checkbox"/> Other (specify) _____
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ASSIGNMENT-Check all applicable tasks. Specify by circling the applicable activity for those items separated by slashes. Write additional precautions, instructions, etc, as needed bedside the appropriate item.

BATH	Bath - Tub/Shower (F1)	ACTIVITY	Ambulation Assist (F8) WC/Walker/Cane
	Bed Bath - Partial/Complete (F2)		Mobility Assist - Chair/Bed/Dangle/Commode/Shower/Tub
	Assist Bath - Chair		ROM - Active/Passive Arm R/L; Leg R/L
			Positioning - Encourage/Assist to Turn q _____ Hrs
			Exercise - Per PT/OT/SLP Care Plan (F10)
HYGIENE/GROOMING	Personal Care (F4)	NUTRITION	Diet Order
	Assist with Dressing		Food Allergies:
	Hair Care - Brush/Shampoo/Other		Meal Preparation (F11)
	Skin Care/Foot Care (Hygiene)		Assist with Feeding
	Check Pressure Areas		Limit/Encourage Fluids
	Shave/Groom/Deodorant		Grocery Shopping (F12)
	Nail Hygiene - Clean/File/Report		
	Oral Care - Brush/Swab/Dentures		
	Elimination Assist		
PROCEDURES	Catheter Care (F6)	OTHER	Wash Clothes (F13)
	Ostomy care		Light Housekeeping (14)
	Record output		Bedroom/Bathroom/Kitchen/Change Bed Linen
	Inspect/Reinforce Dressing (see specifics below)		Equipment Care
	Assist with Medications (see specifics below)		Pain Management
VITALS	T - O/A/R - Record _____ /week - Report	R - Record _____ /week	Weight - Record _____ /Week - Report
	P - Wrist/Pedal, R/L - Record _____ /week - Report	BP - Record _____ /week	Other (specify) _____

Wound Care - Inspect/Reinforce Dressing: _____

 Assist with Meds (describe): _____

 Special Instructions/Safety Measures: _____

SIGNATURES	INITIAL ASSIGNMENT: Signature/Title: _____ Date: ____ / ____ / ____
	THIS ASSIGNMENT SHEET MUST BE REVIEWED AND/OR REVISED AT LEAST EVERY 60 DAYS.
	REVIEWED/REVISED- Signature/Title: _____ Date ____ / ____ / ____
	REVIEWED/REVISED- Signature/Title: _____ Date ____ / ____ / ____

PART 1 - Clinical Record	PART 2 - Patient/Client
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PATIENT/CLIENT NAME - Last, First, Middle Initial: _____ ID#: _____