AA ADVANCED CARE, INC.

CASE CONFERENCE REPORT

PATIENT:_____ MR#_____

DIAGNOSIS:_____

SOC:_____ REPORT DATE:_____

PHYSICIAN:

SUMMARY:_____

PAIN ASSESSMENT FINDINGS:_____

D/C PLAN:_____

CASE MANAGER SIGNATURE:_____

CONFERENCE WITH: (CHECK ALL THAT APPLY)

❑SKILLED NURSE ❑SUPERVISOR ❑ DON ❑PHYSICIAN

❑AIDE ❑PT ❑ OT ❑ MSW

❑ST

WHITE COPY (MEDICAL RECORD) YELLOW COPY (CASE MANAGER)

A & R Home Health Care, Inc.

HOME HEALTH SERVICES INITIAL/OR RESUMPTION OF CARE/RECERTIFICATION
CASE MANAGER REPORT / PHYSICIAN VERBAL ORDER

Patient Name: _____ MR #:_____ SOC Date:_____
ROC/RC Date:_____ Discharge from facility: _____ D/C Date:_____
Physician Name: _____ Physician Address:_____

DIAGNOSIS Primary Diagnosis:_____
First Secondary Diagnosis: _____

VITAL SIGNS Temp: _____ AP (Reg/Irr):_____ RP (Reg/Irr): _____
Resp: _____ BP:_____ WT: _____ HT: _____
HOMEBOUND STATUS: _____
_____

MEDICATION UPON ADMISSION

Circle One:
N O C _____
N O C _____
N O C _____
N O C _____

ASSESSMENT: Diet: _____ Allergies: _____
Lungs: _____ Pulses: _____
Edema: _____ ABD: _____ GI: _____
GU: _____ Skin: _____
Musculoskeletal: _____ Home Env: _____
Wounds: _____ Foley: _____
Functional Limitations: _____
Mental Status: _____ Living Arrangements:_____

PRIMARY REASON FOR HOME CARE: _____
_____
_____
_____
_____

ORDERED SERVICE TO PROVIDE: Admission Nurse: _____

SN:	FREQUENCY:
AIDE:	FREQUENCY:
PT:	FREQUENCY:
MSW/OTHER:	FREQUENCY:

RN Case Manager: _____ Date: _____

Physician Signature: _____ Date: _____

Date Received: _____

BetLife
HEALTHCARE CORP

MEDICATION MANAGEMENT CASE CONFERENCE

Patient Name:____ MR#______________ Date:______________
Case Conference with SN re: Medications management. During the last week patient/caregiver reports:
Compliance with Medications regime Yes ________ No _________
Patient/caregiver instructed in action /side effects/adverse effects reactions to ______________________________
Verbalizes understanding: Yes_____ No______ requires additional instructions___________
Adverse reactions/side effects noted No_____ Yes_____ (describe fully) ____
____
Physician contacted: No______ Yes_____ Orders received:____
____
Other:____
____

____
Signature/Title

Date:_______________________
Case Conference with SN re: Medications management. During the last week patient/caregiver reports:
Compliance with Medications regime Yes ________ No _________
Patient/caregiver instructed in action /side effects/adverse effects reactions to ______________________________
Verbalizes understanding: Yes_____ No______ requires additional instructions___________
Adverse reactions/side effects noted No_____ Yes_____ (describe fully) ____
____
Physician contacted: No______ Yes_____ Orders received:____
____
Other:____
____

____
Signature/Title

Date:_______________________
Case Conference with SN re: Medications management. During the last week patient/caregiver reports:
Compliance with Medications regime Yes ________ No _________
Patient/caregiver instructed in action /side effects/adverse effects reactions to ______________________________
Verbalizes understanding: Yes_____ No______ requires additional instructions___________
Adverse reactions/side effects noted No_____ Yes_____ (describe fully) ____
____
Physician contacted: No______ Yes_____ Orders received:____
____
Other:____
____

____
Signature/Title

Date:_______________________
Case Conference with SN re: Medications management. During the last week patient/caregiver reports:
Compliance with Medications regime Yes ________ No _________
Patient/caregiver instructed in action /side effects/adverse effects reactions to ______________________________
Verbalizes understanding: Yes_____ No______ requires additional instructions___________
Adverse reactions/side effects noted No_____ Yes_____ (describe fully) ____
____
Physician contacted: No______ Yes_____ Orders received:____
____
Other:____
____

____
Signature/Title

CALURA HOME HEALTH

CASE CONFERENCE/60 DAY SUMMARY

PATIENT NAME: _____ MR#: _____

START OF CARE: _____

PHYSICIAN: _____

PERIOD REVIEWED FROM: : ____/____/____ TO: ____/____/____

☐ 60 DAY SUMMARY
☐ CASE CONFERENCE
☐ TRANSFER
☐ DISCHARGE

STATUS ON ADMISSION OR RECERTIFICATION PERIOD:

☐ ALERT ☐ ORIENTED ☐ DISORIENTED ☐ FORGETFUL ☐ OTHER: _____

_____

_____

_____

SERVICES PROVIDED: ☐ SN ☐ AIDE ☐ PT ☐ OT ☐ MSW ☐ ST ☐ NUTR ☐ RESPIRATORY

_____

_____

_____

_____

☐ PROGRESS
☐ STABLE
☐ DETERIORATION

☐ HOSPITALIZED FROM: _____ TO _____
☐ VERBAL ORDERS OBTAINED: _____
_____
_____

BSL: ☐ STABLE
☐ UNSTABLE: _____

BP: ☐ STABLE
☐ UNSTABLE: _____

☐ PROBLEMS: _____

☐ RESPONSE: _____

☐ OTHER: _____

_____

PLAN FOR FOLLOW UP/RECOMMENDATIONS:

☐ CONTINUE WITH SAME PLAN OF CARE ☐ OTHER:

_____

_____

CASE CONFERENCE PARTICIPANTS:

_____

_____

CHERRY HOME
HEALTH SERVICES, INC.

PATIENT'S CASE CONFERENCE/60 DAYS SUMMARY

PATIENT NAME _____ **PATIENT NUMBER** _____
START OF CARE_____ PHYSICIAN _____

REASON: []DISCHARGE []TRANSFER **[]CASE CONFERENCE [] 60 DAY SUMMARY**
NOTIFIED: PHYSICIAN: [] YES [] NO

STATUS ON ADMISSION OR RECERTIFICATION PERIOD:

_____
_____
_____
_____

SERVICES PROVIDED SN PT ST OT MSW AIDE NUTR RESPIRATORY (Briefly description)

_____
_____
_____
_____

PROGRESS/DETERIORATION / PROBLEMS/RESPONSE/GOALS:

_____
_____
_____
_____
_____
_____

	MET				**MET**		
PT'S BILL OF RIGHTS	[]YES	[]NO	[] N/A	**INDEPENDENT**	[]YES	[]NO	[]PARTIAL
WOUND/DECUBITUS/SURGERY HEALED	[]YES	[]NO	[] N/A	AMB.	[]YES	[]NO	[]PARTIAL
SYMPTOM CONTROL	[]YES	[]NO	[] PARTIAL	TRANSFER	[]YES	[]NO	[]PARTIAL
VITAL SIGNS STABLES	[]YES	[]NO	[] PARTIAL	ADL's	[]YES	[]NO	[]PARTIAL
BLOOD SUGAR RANGE _____	[]YES	[]NO	[] N/A	DME USE	[]YES	[]NO	[]PARTIAL
UNDERSTANDS / COMPLIES	[]YES	[]NO	[] PARTIAL	**STABLE**	[]YES	[]NO	[]PARTIAL
MEDICATIONS	[]YES	[]NO	[] PARTIAL	CARDIAC	[]YES	[]NO	[]PARTIAL
DIET REGIMEN	[]YES	[]NO	[] PARTIAL	RESP	[]YES	[]NO	[]PARTIAL
TREATMENT PROGRAM	[]YES	[]NO	[] PARTIAL	NUTRITION	[]YES	[]NO	[]PARTIAL
SIGNS AND SYMPTOMS	[]Y ES	[]NO	[] PARTIAL	G.I.	[]YES	[]NO	[]PARTIAL
SAFETY MEASURES	[]YES	[]NO	[]PARTIAL	G.U.	[]YES	[]NO	[]PARTIAL
GOALS ACHIEVED	[]YES	[]NO	[]PARTIAL	MENTAL	[]YES	[]NO	[]PARTIAL

CASE CONFERENCE PARTICIPANTS:

_____
_____
_____

Case Conference at: BY PHONE [ ] PATIENT'S HOME [ ] OFFICE [ ]
PLANS FOR FOLLOW-UP/RECOMMENDATIONS:

_____
_____
_____
_____

STAFF SIGNATURE _____ DATE _____

County Wide Home Care, Inc.
6501 NW 36 St.
Suite 401
Miami, FL 33166
Ph: (305) 526-7755
Fax: (305) 526-7755

CASE CONFERENCE

Date: _____

Patient: _____ MR#: _____

_____
Discipline Signature & Date

Health Home Care, Inc.

CASE CONFERENCE LOG

YEAR ______________

MEDICAID/BASIC

PATIENT'S NAME	MR#	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC

Health Home Care, Inc.

CASE CONFERENCE LOG

YEAR ______________

MEDICARE/MEDICAID SKILL

PATIENT'S NAME	MR#	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC

Health Home Care, Inc.

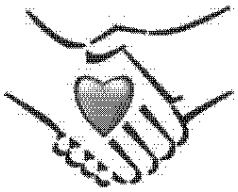
CASE MANAGER F/U					
Patient Name:					
MR#:		SOC:			
Date:		S.N. Frequency:		D/C:	

Phys. Therapy Evaluation	Frequency	D/C:

MOD'S	Notes	D/C:

Hospitalization	ROC	D/C:

Transfer To Medicaid:	



HOME CARE SERVICES PROVIDER

CASE CONFERENCE REPORT

Med. Record: _____

Patient: _____ Date of Conference: _____/_____/_____

Diagnosis:

_____
_____
_____
_____

SOC: _____/_____/_____ Cert. Period: _____/_____/_____ - _____/_____/_____

Physician Name: _____

Address: _____

_____

Problems Addressed / Summary of Condition:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Disciplines Involved:

Case Manager: _____ Other: _____

S.N.: _____

AIDE: _____

Maxmed, Inc.

□ **Initial Case Conference**
□ **Recertification/ROC**
□ **30 Day Case Conference**

PATIENT NAME	**VISIT TYPE**	**MD VISITS:**
MR#	□ SOC Frequency _____ □ Recert / ROC □ PRN Visit Date _____ □ P.T. Evaluation □ Other: _____ Allergies _____	Date of Last _____
DX:		

TEMPERATURE (AX) ____	**PULSES:**	**WEIGHT:**	**BLOOD PRESSURE:**
RESPIRATION _____	Radial _____	_____ □ Actual □ Stated □ Unable □ Patient Scale □ MAXMED, INC. Scale	Standing □ Left _____ □ Right _____ Sitting □ Left _____ □ Right _____ Lying: □ Left _____ □ Right _____
Blood Sugar Range: _____ AM/PM	Apical _____		

CARDIOVASCULAR
□ Pulse Regular
□ Pulse Irregular
□ Abnormal Heart Sounds _____
□ Chest Pain _____
□ Edema/Fluid Retention _____
□ Neck Vein Distention
□ Pedal Pulses
L _____ R _____
□ Numbness □ Varicous
□ Tingling Veins
□ Other:
_____
_____
_____
_____
□ Assessment Done

RESPIRATORY
□ Lung Sounds Clear
□ Abnormal Breath Sounds
_____
_____
□ Respiration Labored
□ Respiration Unlabored
□ Cough
□ Sputum _____
_____
□ Shortness of Breath/ DOE
_____
□ Pallor/Cyanosis
□ O2 _____
□ Nebulizer
□ Other _____
_____
□ Assessment Done

MUSCULOSKELETAL AND MOBILITY
□ Endurance: _____ ft.
□ ROM
□ Bed Bound
□ Transfer Bed/Chair
□ Gait Steady
□ Gait Unsteady
□ Partial Weight Bearing
□ Non-weight Bearing
□ Non-ambulatory
□ Pain
□ Weakness
□ Prosthesis: _____
_____
□ Amputation: _____
_____
□ Poor balance
□ Other _____
□ Assessment Done

MENTAL & EMOTIONAL
□ Oriented □ Labile
□ Cooperative □ Agitated
□ Disoriented □ Fearful
□ Forgetful □ Anxious
□ Withdrawn
□ Depressed
□ Lethargic
□ Special Needs
□ Social Isolation
□ Comatose
□ Paranoid
□ Delusional
□ Hallucinations
□ Dim. Thought Process
□ Poor Coping Skills
□ Affect _____
□ Other
_____
□ Assessment Done

NEUROLOGICAL
□ Awake □ Alert
□ Drowsy
□ Headache
□ Dizziness
□ Visual Deficit
_____
□ Hearing Deficit
_____
□ Speech Difficulty
□ Swallowing Difficulty
□ Pupils Unequal
□ Pupils Response
L _____ R _____
□ Hand Grasp
L _____ R _____
□ Other
_____
□ Assessment Done

COMFORT
□ Absence of Pain
□ Complaint of Pain
□ Location _____
_____
Severity:
1 2 3 4 5 6 7 8 9 10
MILD SEVERE
□ Pain Control Measures
Frequency _____
Response _____
□ Increased Pain with Activity
□ Relieve with: _____
_____
□ Other: _____
□ Assessment Done

NUTRITIONAL AND HYDRATION
Appetite
□ Good □ Fair □ Poor
□ TPN: _____
□ Regular □ Renal
□ Low Fat Diet
□ Low N/A □ Bland
□ No Concentrate sweets
□ G-tube Feeding:
_____
□ Recent Weight Change
□ Gain □ Loss
□ Other: _____
_____
_____
□ Assessment Done

GASTROINTESTINAL
□ No Identified Problems
□ Bowel Sounds x 4
□ Last BM _____
□ Diarrhea
□ Constipation
□ Nausea
□ Vomiting
□ Incontinence
□ Abdominal Girth
□ Laxative Use
□ Ostomy
_____
□ Other _____
_____
_____
□ Assessment Done

GENITOURINARY
□ No Identified Problems
□ Incontinence
□ Retention
□ Foley Catheter # _____
□ Urine Characteristics
_____
□ Burning
□ Pain
□ Urgency
□ Frequency
□ Ostomy
_____
□ Other _____
_____
□ Assessment Done

SKIN
□ Normal □ Dry
□ Warm □ Cold
□ Diaphoretic
□ Color □ Turgor
□ Lesions □ Fair
□ Rash □ Poor
□ Incision: _____
□ Wound Location:
_____
_____
_____
_____
_____
_____
_____

HOMEBOUND STATUS
□ Need Assist with all activities
□ Residual weakness
□ Non-Ambulatory
□ Confusion
□ Severe Dyspnea
□ Leaving home requires a considerable taxing effort
□ Severe pain
□ Other: _____
_____
_____
_____

MEDICATIONS
□ IM
□ IV
□ SQ
□ PQ
Medication/Dose/Freq
_____
_____
_____
_____
_____
_____
_____

VENOUS ACCESS
□ Not Applicable
□ Hickman
□ Mediport
□ PICC
□ Groshong
□ Portacath
Location _____
Appearance _____
_____
□ Single Lumen
□ Double Lumen
□ Triple Lumen

IV SITE CARE
□ Not Applicable
□ Cap Change
Frequency _____
□ Dressing Change
Describe _____
_____
□ Flush
Describe _____
_____
□ Extension Tubing
Change _____
_____
_____

COMMENTS:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient's Procedures and or Instructions:

PATIENT NAME: _____ **MR:** _____

□ **GU Instruction**
□ Catheter
□ Insertion
□ Irrigation
□ Change Catheter
Q: _____

□ **Wound Care**
□ Instruction
□ Performed
Wound care Freq:
□ Daily
□ QOD
□ Other: _____

□ **GI Instruction**

□ Establish Bowel regimen
□ Enema Adm

□ Disimpaction

Supplies: _____
_____
DME: _____
_____

□ **Nutrition/ Instruction**
□ Assess Compliance
□ Feeding Tube:
□ Bolus: _____ cc
□ Freq: _____
□ Pump _____ cc/h

□ **DM Instructions**
□ Diabetic Management
□ Glucometer
□ BS Monitor freq:
_____

□ Diet Teaching

□ Insulin Adm

□ Diabetic Inst

□ **Ostomy Care Stoma Inspection**
□ Appliance
□ Change
□ Irrigation
□ Maintenance

□ **Respiratory Instruction**
□ Tracheostomy Care
□ Nebulizer
□ Oxygen Administration
□ O2 ____ LPM SOB with Activity

□ **IV Catheter Care Instruction**

□ **Maintenance Freq:** _____

□ **Pt/PCG Return**

□ **Demonstration of:**
_____
_____
_____
_____

□ **Walker** □ **Cane**
□ **Hoyer Lift**
□ **Other:** _____
_____
_____
_____

□ **Instruction/DME**
_____
_____
_____

□ **Cardiac Instruction**
□ Check pulse
□ Check for Edema
□ Check gain WT

□ **Safety Instructions**
□ Standard Precautions
□ Standard Measures In the Home
□ Waste Disposal

□ Disease Process

□ **Equipment Needs**

□ **Assessment/Instructed**

□ **Telephone Physician Called to:**

□ Report Condition

□ Request Further Orders

□ **Orders**
_____

□ **Management/ Evaluation POC**
_____
_____

□ **LPN Sup Q 30 Days**
□ **HHA Supervision Q 14 Days**
□ **Care Plan/Changes**

□ Discussed with Patient
□ Caregiver
□ Visit Frequency
□ **Discussed**
□ **Discharge Plan With**

Patient/PCG
□ **Conference With**
_____
Staff _____
_____

□ Other _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Problems	Skilled intervention	Frequency
		SN:
		PT:
		Social Services:
		HHA:
SN Signature:		**Date:**

NEW HEALTH CARE, CORP.

CASE CONFERENCE/60 DAY SUMMARY ☐ Transfer ☐ Discharge

Patient Name: _____ Date: _____ MR#: _____
Physician: _____ **NURSING FREQUENCY:** _____

Homebound Status: _____
Medicaiton/Treatment change ☐ Yes ☐ No Description: _____

☐ Significant change in general condition ☐ Unstable V/S requiring freq MD contact ☐ SAN ☐ Wound Care
☐ Questionable med effectiveness ☐ Impaired wound healing process ☐ O2 ☐ Injection
☐ Symptons of infection ☐ Unreliable with meds/needs instruction ☐ Foley cath ☐ Lab
☐ Slow to comprehend medical tx. instruct ☐ Poor nutritional intake/hydration ☐ PEG
☐ Poor bowel/bladder management ☐ Complicated medical treatment required ☐ Tube fedding
☐ Prep/Adm. of Insulin ☐ Other: _____

PLAN:
☐ Observation & Assessment ☐ Management & Evaluation of Pt. Care Plan ☐ Teaching/Training ☐ Procedures/Treatment
REVIEW: _____

SOCIAL SERVICES: _____
☐ Living arrangement unsafe or inadequate for level of care
☐ Family unable to cope with situation
☐ Suspect physical/emotional abuse or neglect
☐ Pt. overwhelmed with condition
☐ Pt. having difficulty following medical treatment
☐ Pt.'s emotional status label _____
☐ Pt. is socially isolated
☐ Pt. needs financial assistance _____
☐ Other _____
☐ Supplemental order written _____

HOME HEALTH AIDE: _____
☐ Difficulty with self care (bed, bath, shower, shampoo)
☐ Lacks willing/able/available caretaker
☐ Has need for light housework
☐ Has need for light meal prep/laundry
☐ Unsafe in performing ADL's
☐ Observed changes in pt. condition _____
☐ Assist. With PT, OT, ST as instructed by discipline
☐ Other _____
☐ Supplemental order written _____

PHYSICAL THERAPY: _____
☐ Difficulty in transfers
☐ I Upright tolerance/endurance
☐ Poor safety/balance
☐ I 'd ROM/strength _____
☐ Painful _____
☐ Difficulty with gait _____
☐ Equipment ☐ Cane ☐ Walker
☐ Modalities required _____
☐ Difficulty with pt./family follow through _____
☐ Other _____
☐ Supplemental order written _____

OCCUPATIONAL THERAPY: _____
☐ Difficulty with ADL's _____
☐ I Upright tolerance/endurance
☐ I 'd ROM/strength _____
☐ I 'd fine/gross motor coordination
☐ Problems with energy conservation, work simplification, self-pacing
☐ Painful _____
☐ Difficulty with cognitive/perceptual motor
☐ Difficulty with pt./family follow through
☐ Other _____
☐ Supplemental order written _____

SPEECH THERAPY: _____
☐ Difficulty with receptive communication _____
☐ Difficulty with expressive communication _____
☐ Other _____
☐ Poor gag reflex, swallowing problems, drooling
☐ Disoriented/confused
☐ Supplemental order written _____

Date Discharged from:
SN _____ PT _____ OT _____ ST _____ MSW _____ HHA _____
Case Members: SN _____ PT _____ OT _____ ST _____
MSW _____ HHA _____

STAFF SIGNATURE: _____

YEMA HOME HEALTH CARE, INC.

7485 Coral Way, MIAMI, FLORIDA 33155
TEL: (305) 262-2287

CASE / TEAM CONFERENCE

Patient's name: _____

Physician's name: _____

Disciplines and individuals participating:

_____

Problems addressed: _____

Plan: _____

_____ _____

Signature of Director or Nursing or case Manager Date