

INDIVIDUAL CARE PLAN – HOME CARE

Reason for Services
Other Medical Conditions

Allergies: <i>(describe reaction(s))</i> <input type="checkbox"/> Drug: <input type="checkbox"/> Food: <input type="checkbox"/> Latex:	<input type="checkbox"/> Environment: <input type="checkbox"/> Other: <input type="checkbox"/> Facility specific Allergy/Intolerance record completed (if applicable)
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MISCELLANEOUS INFORMATION

Key Contact:
Other Contacts:
Advance Care Plan (Health Care Directive): <i>(include location kept)</i>
Legal Medical Substitute Decision Maker: <i>(include ph#)</i> <input type="checkbox"/> Proxy <input type="checkbox"/> Personal Guardian <input type="checkbox"/> Nearest relative
Financial Power of Attorney: <i>(include ph#)</i>
Case Manager/RN:

TB test: <i>(date)</i>	Results:	Pneumovax: <i>(date)</i>	Influenza Immunization: <i>(dates)</i>
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	INITIATOR	DESIRED OUTCOME	REVIEW	INITIATED	CARE GIVER TYPE	INTERVENTIONS	DISC
			DATE	DATE			DATE
			ID	ID			ID
PERSONAL HYGIENE							
ELIMINATION							
NUTRITION							

	INITIATORS	DESIRED OUTCOME	REVIEW	INITIATED	CARE	INTERVENTIONS	DISC
			DATE	DATE	GIVER		DATE
			ID	ID	TYPE		ID
MOBILITY							
OBS AND MEAS							
MEDS							
TX AND PRO							
TEACHING							
SAFETY							
PSYCHOSOCIAL							
HOMEMAKING							

