INDIVIDUAL CARE PLAN – HOME CARE

Reason for Services

Other Medical Conditions

Allergies: *(describe reaction(s))*
☐ See Facility specific Allergy/Intolerance record
☐ Drug:
☐ Food:
☐ Latex:
☐ Environment:

MISCELLANEOUS INFORMATION

Key Contact:

Other Contacts:

Advance Care Plan (Health Care Directive): ☐ Yes ☐ No ☐ On file Location: _____

Legal Substitute Health Care Decision Maker: *(include ph#)*
☐ Proxy ☐ Personal Guardian ☐ Nearest relative

Financial Power of Attorney: *(include ph#)*

Case Manager/RN:

TB test: *(date)* **Results:** | **Immunizations:** *(dates)*

Precautions for AROs *(date)*
VRE: Other:
MRSA: Decolonization protocols initiated: ☐ Yes ☐ No

	INITIATOR	DESIRED OUTCOME	REVIEW DATE / ID	INITI… DATE / ID	CARE …	INTERVENTIONS	DISC DATE / ID
PERSONAL HYGIENE							
ELIMINATION							
NUTRITION							
MOBILITY							

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