INDIVIDUAL CARE PLAN – HOME CARE

Reason for Services

Other Medical Conditions

Allergies: *(describe reaction(s))*

☐ **Drug:**

☐ **Food:**

☐ **Latex:**

☐ **Environment**:

☐ **Other:**

☐ Facility specific Allergy/Intolerance record completed (if applicable)

MISCELLANEOUS INFORMATION

Key Contact:

Other Contacts:

Advance Care Plan (Health Care Directive): *include location kept)*

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

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

Case Manager:

TB test: *(date)* **Results:**	**Pneumovax:** *(date)*	**Influenza Immunization:** *(date)*

	INITIATOR	DESIRED OUTCOME	REVIEW DATE / ID	INITIATED DATE / ID	CARE GIVER TYPE	INTERVENTIONS	DISC DATE / ID
PERSONAL HYGIENE							
ELIMINATION							

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Initiators		Desired Outcome	Review Date / ID	Initiated Date / ID	Care Giver Type	Interventions	disc Date / ID
Nutrition							
Mobility							
Observations and Measurements							

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INDIVIDUAL CARE PLAN – HOME CARE

	INITIATORS	DESIRED OUTCOME	REVIEW DATE / ID	INITIATED DATE / ID	CARE GIVER TYPE	INTERVENTIONS	DISC DATE / ID
MEDICATIONS							
TREATMENTS AND PROCEDURES							
TEACHING							

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	INITIATORS	DESIRED OUTCOME	REVIEW DATE / ID	INITIATED DATE / ID	CARE GIVER TYPE	INTERVENTIONS	DISC DATE / ID
SAFETY							
PSYCHOSOCIAL							
HOMEMAKING							

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