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

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:

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

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

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

INDIVIDUAL CARE PLAN – HOME CARE

	INITIATORS	DESIRED OUTCOME	REVIEW DATE / ID	INITIATED DATE / ID	CARE GIVER TYPE	INTERVENTIONS	DISC DATE / ID
NUTRITION							
MOBILITY							
OBSERVATIONS AND MEASUREMENTS							

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							

INDIVIDUAL CARE PLAN – HOME CARE

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