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| MERAKI HOME HEALTH SOLUTIONS LLC |
| Care Plan |
| Plan created by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |



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| **HOME CARE PLAN** | | | | | | | | | | |
| CLIENT NAME |  | | | DOB |  | | AGE |  | | |
| ADDRESS |  | | | | | | PHONE |  | | |
| NAME OF EMERGENCY CONTACT | | |  | PHONE |  | | EMAIL |  | | |
| NAME OF FAMILY PHYSICIAN | | |  | PHONE |  | | EMAIL |  | | |
| MED. PROFESSIONAL (INVOLVED) | | |  | TYPE |  | | PHONE |  | | |
| PRIVATE CAREGIVER (INVOLVED) | | |  | VISITS | YES NO | | PHONE |  | | |
| CURRENT CARE ALERT INFORMATION | | | | | | | | | | |
| **CARE ALERT** | FALL RISK WANDERS POOR VISION POOR HEARING CONFUSION DIFFICULTY W/ VERBAL COMMUNICATING DIFFICULTY W/ NON-VERBAL COMMUNICATION | | | | | | | | | |
| MEDICAL DIAGNOSIS | | |  | | | | | | | |
|  | | | | | | | | | | |
| CURRENT PHYSICAL / MENTAL ISSUES TO BE AWARE OF | | | | | | | | | | |
|  | | |  | |  | | | | | |
|  | | |  | |  | | | | | |
| RECENT PATIENT HISTORY & DATES (HOSPITAL EMERGENCY VISITS, FALLS ETC.) | | | | | | | | | | |
|  | |  |  |  |  | | | | |  |
|  | |  |  |  |  | | | | |  |
| PRESENT LIST OF MEDICATIONS | | |  | | | | | | | |
|  | | |  | |  | | | | | |
|  | | |  | |  | | | | | |
| LIST ANY PRESENT ALLERGIES | | |  | | | | | | | |
| FOOD SENSITIVITIES | | |  | | | | | | | |
| FOOD LIKES | | |  | | | | | | | |
| FOOD DISLIKES | | |  | | | | | | | |
| **LIFESTYLE SUPPORT NEEDS** | | | **GOAL OF CARE** | **CARE OR INTERVENTION REQUIRED** | | | | | | |
| **MEDICATION** | | | **MEDICATIONS ARE MANAGED SAFELY & CORRECTLY** | **LEVEL OF ASSISTANCE REQUIRED** | | | | | | |
| POSSIBLE SIDE EFFECTS: | | | Extensive prompting  Stay close by to observe  Nurse administers medication | | | Self-administers medication  Other | | | |
| **PAIN MANAGEMENT- INDICATE X**  A picture containing linedrawing  Description automatically generated | | | **REMAIN PAIN FREE** | **PERSONAL CARE** | | | **SOCIAL STIMULATION** | | | |
| **SIGNS SENIOR IS IN PAIN** | **NEED ASSISTANCE WITH** | | | **INTRESTS/ACTIVITIES** | | | |
|  |  | | |  | | | |
| **WHAT IS MOST COMFORTING** | **WAKE UP TIME** | |  | **BEDTIME** | |  | |
| \*PHYSICALLY / MENTALLY | \*ROUTINE | | | \*ROUTINE | | | |
|  |  | | |  | | | |
| **COMMUNICATION** | | | **THAT RESIDENT MAINTAINS A GOOD LEVEL OF WAYS TO COMMUNICATE THOUGHTS/FEELINGS** | VISION AID REQUIRED | | | YES NO | | | |
| DIFFICULTY OK GOOD | | | HEARING AID | | | YES NO | | | |
| BEST FORM OF COMMUNICATION: | | | SPEECH THERAPY | | | YES NO | | | |
| NOTES: | | | | | | |
| **PLEASE REFER TO THE CARE ASSESSMENT FOR MORE DETAILED INFORMATION** | | | | | | | | | | |



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| **CLIENT CARE PLAN FOR CAREGIVER** |

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| **CLIENT NAME:** |  | | | | | **DATE:** |  | | |
| **ASSIGNED CAREGIVER:** | |  | | **TIME IN-OUT:** | | |  | **TO** |  |
| **SUPERVISOR:** |  | | | | **CONTACT:** | |  | | |
| **PERSON RESPONSIBLE FOR CARE PLAN:** | | |  | | **POSITION:** | |  | | |

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| **LOCATION** | | | | | | | | | | | | | |
|  | **HOME** | |  | **LONG TERM CARE RESIDENCE** | | |  | **CARE FACILITY** |  | **OTHER** | | | |
| FACILITY: | |  | | | | ADDRESS: | |  | | | ROOM#: | |  |
| HOME ADDRESS: | | | | |  | | | | ENTRANCE CODE: | | |  | |

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| **CLIENT INFORMATION** | | | | | | | | | | | | | | |
| FILE NUMBER#: |  | | | | | | | | | | | | | |
| D.O.B [MM/DD/YY]: |  | | | | HEIGHT: | |  | | | | WEIGHT: | | |  |
| LEVEL OF ASSISTANCE: |  | | SUPERVISION | |  | PARTIAL ASSISTANCE | | | |  | COMPLETE ASSISTANCE | | | |
| NO# OF CAREGIVERS: |  | | | | | | | | | | | | | |
| EQUIPMENT REQUIRED: |  | | | | | | | | | | | | | |
| ALLERGIES: |  | | | | | | | | | | | | | |
| COGNITION IMPAIRMENT: | |  | | NONE |  | LOW | |  | MEDIUM | | |  | HIGH | |
| PHYSICAL IMPAIRMENTS: | |  | | | | | | | | | | | | |

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| **CARE INSTRUCTIONS** | |
| **CARDIO/RESPIRATORY:** |  |
| **NUTRITION:** |  |
| **ELIMINATION/TOILETING:** |  |
| **HYGIENE:** |  |
| **MOBILITY/TRANSFERS:** |  |
| **SLEEP & REST:** |  |
| **DRESS & UNDRESS:** |  |
| **AVOID DANGERS:** |  |
| **COMMUNICATION:** |  |
| **ACTIVITIES:** |  |
| **PAIN MANAGEMENT:** |  |
| **ADDITIONAL NOTES:** |  |