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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:** |  |