Client Care Plan

History taken from:
Date/Time of Assessment:

Client Name:

Address:

Directions:

Telephone #s: Home Cell:

Email:

Birthdate (month/day/year):

Next of Kin (name, relationship, contact #s, location):
1.

2.

Who does the client live with?

Family Doctor (name, address, phone #):

Specialist (name, address, phone#):

OT/PT/Dietician (name, address, phone#):

Pharmacy (name, address, phone #):

Allergies incl. reactions (medications, food, environmental):

Height: Weight:

Verbal/Non-verbal:

Diet (special needs/restrictions):

Wears glasses Y/N

ACUTE SAFETY CONCERNS:

MEDICAL CONDITIONS:

☐ Diabetes (insulin/oral medications/diet controlled):

☐ Heart (MI, CHF, And Atrial Fibrillation):

☐ Lungs/Breathing (COPD, Asthma, Pulmonary Fibrosis):

☐ Blood Pressure (high, low):

☐ Cancer (location, date, surgery, metastatic?):

☐ Arthritis/ Musculoskeletal conditions:

☐ Stroke:

☐ Dementia/Memory (short term memory, long term memory):

☐ Bowel/Bladder/Kidney:

☐ Mental Health/Addictions:

☐ Neurological (Parkinson's, Epilepsy, ABI):

☐ Autoimmune Disorders/Thyroid:

☐ Skin /Wounds (location, size):

☐ Gastrointestinal (colitis, ulcers, constipation):

☐ Chronic Pain Conditions:

☐ Other:

ACTIVITIES OF DAILY LIVING:

☐ Meals (independent, assistance, dependent)

☐ Dressing (independent, assistance, dependent)

☐ Bathing (independent, assistance, dependent)

☐ Toileting (continent/incontinent)(independent, assist, dependent)

☐ Grooming (independent, assistance, dependent)

☐ Walking (Aids-independent, assistance, dependent)

INTERESTS/HOBBIES/SOCIAL ACTIVITIES:

USUAL PATTERNS:

Nutrition:

Sleep/Rest:

Activity level/Exercise:

Coping/Stress management:

SUPPORT SYSTEMS (family, social):

CLIENT GOALS:

MEDICATIONS:

Name	Dosage	Route	Frequency	Reason

OTHER NOTES:

CARE SERVICE ARRANGEMENTS:

Services requested by client:

☐ Homemaker/Companion

☐ PSW/DSW/CYW

☐ RPN

☐ RN

Services to be provided:

☐ Meal Preparation (likes/dislikes)

☐ Respite

☐ Appointments/Errands

☐ Medication Reminder/Medication Administration

☐ Bathing/Dressing

☐ Light Exercise

☐ Other/Liasons /Referrals

Frequency of care: