CARING for People Services®

AIDE CARE PLAN

Patients Name:	DOB:	
Street Address: Phone #:		
City:	State:	Zip:

Emergency Contact/Relationship: Phone #:
Days Needed: □ Monday □ Tuesday □ Wednesday □ Thursday □ Friday □ Saturday □ Sunday
Times Needed:
Client Dx/Problem: _____
_____

PRECAUTIONARY AND OTHER PERTINENT INFORMATION - Check all that apply

□ Lives alone □ Lives with other □ Alone during the day □ Bed bound □ Bed rest/BRPs □ Up as tolerated □ Amputee (specify): ____ _____ □ Partial weight bearing □ R □ L	□ Non-weight bearing: □ R □ L □ Fall precautions □ Speech/Communication deficit □ Vision deficit: □ Glasses □ Contacts □ Other: _____ Hearing deficit: □ Hearing Aid	□ Dentures: □ Upper □ Lower √ Partial □ Forgetful/Confused □ Urinary catheter □ Prosthesis (specify):___ _____ □ Allergies (specify): _____ _____	□ Diabetic □ Do not cut nails □ Diet: _____ □ Seizure precaution □ Prone to fractures □ Other (specify):_____ □ _____ □ _____ □ _____

	Assignment	Every Visit	Wk	Other Comments/Instructions
Bath	Tub/Shower	□	□	
	Bed Bath-Partial/Complete	□	□	
	Assist Bath Chair	□	□	
Personal Care	Personal Care	□	□	
	Assist w/ dressing	□	□	
	Groom Hair	□	□	
	Shampoo	□	□	
	Skin Care	□	□	
	Teeth Care	□	□	
	Other (specify): _____	□	□	
Procedures	Toileting Assist	□	□	
	Catheter Care	□	□	
	Ostomy Care	□	□	
	Medication Reminder	□	□	
	Other (specify): _____	□	□	

	Assignment	Every Visit	Wk	Other Comments/Instructions
Activity	Assist w/ Ambulation W/C / Walker / Cane	□	□	
	Mobility Assist Chair/Bed Shower/Tub	□	□	
	Exercise - Per PT/OT Care Plan	□	□	
	Other (specify): _____	□	□	
Nutrition	Meal Preparation	□	□	
	Assist with Feeding	□	□	
	Limit/Encourage Fluids	□	□	
	Grocery Shopping	□	□	
	Other (specify): _____	□	□	
Other	Laundry	□	□	
	Light Housekeeping Bedroom/Bathroom/ Kitchen/Bed Linen	□	□	
	Equipment Care	□	□	
	Transportation _____	□	□	