Plan of Care

Client Name _____ Date: _____

Personal Care	Comments
❑ Bath/shower/sponge bath	_____
❑ Hair/shampoo	_____
❑ Nails	_____
❑ Mouth care	_____
❑ Teeth/dentures	_____
❑ Assist with dressing	_____
❑ Assist with toileting	_____
❑ Transfer to chair/wheelchair	_____
❑ Shave	_____
❑ Skin care	_____
❑ Medications	_____

Nutrition	Comments
❑ Meal planning	_____
❑ Food shopping	_____
❑ Meal preparation	_____
❑ Feeding assistance	_____
❑ Clean-up/dishes	_____

Light Housekeeping	Comments
❑ Dusting	_____
❑ Vacuuming	_____
❑ Sweeping	_____
❑ Mopping	_____
❑ Change bed linens	_____
❑ Remove trash & remove waste paper baskets	_____
❑ Set trash out for pickup	_____
❑ Clean window sills & baseboards	_____
❑ Polish silver	_____
❑ Laundry/ironing	_____

- ❑ Minor clothing repairs _____
- ❑ Water plants _____
- ❑ Shopping/errands _____
- ❑ Bedroom(s) _____
- ❑ Bathroom(s) _____
  - ❑ Tub _____
  - ❑ Toilet _____
  - ❑ Shower _____
- ❑ Kitchen _____
  - ❑ Cabinets _____
  - ❑ Stove _____
  - ❑ Counter top _____
- ❑ Living room _____
- ❑ Dining room _____
- ❑ Other: _____
  - ❑ _____ _____
  - ❑ _____ _____
  - ❑ _____ _____

Activities	Comments

- ❑ Reading _____
- ❑ Exercise _____
- ❑ Outings/driving _____
- ❑ Luncheons _____
- ❑ Television _____
- ❑ Reminiscing _____
- ❑ Games _____
- ❑ Visiting friends _____
- ❑ Appointments _____

Comments/Special Instructions _____

American Family Home Health Agency LLC

Medication Alert	Breakfast				Lunch				Dinner						
	6 AM	7 AM	8 AM	*	12 PM	1 PM	2 PM	*	6 PM	7 PM	8 PM	*	10 PM	11 PM	*

Daily Routine

Wake-up _____

AM Activities _____

Lunch _____

PM Activities _____

Dinner _____

Bedtime _____

Night _____

Comments/Special Instructions _____

_____

_____

_____

_____

_____ _____ _____ _____

Patient Signature Date RN Signature Date

_____