

PERSONAL CARE

Plan of Care

Month

Year

Last Name	First Name	Middle Name	DOB	Service Level <input type="checkbox"/> 1 <input type="checkbox"/> 2
Plan of Care by: _____ RN Signature			Date _____	
			Plan Period (Month & Year):	

Date: Check correct day (Any change in schedule must be pre-approved and documented on back.)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	9 <input type="checkbox"/>	10 <input type="checkbox"/>	11 <input type="checkbox"/>	12 <input type="checkbox"/>	13 <input type="checkbox"/>	14 <input type="checkbox"/>	15 <input type="checkbox"/>	
	16 <input type="checkbox"/>	17 <input type="checkbox"/>	18 <input type="checkbox"/>	19 <input type="checkbox"/>	20 <input type="checkbox"/>	21 <input type="checkbox"/>	22 <input type="checkbox"/>	23 <input type="checkbox"/>	24 <input type="checkbox"/>	25 <input type="checkbox"/>	26 <input type="checkbox"/>	27 <input type="checkbox"/>	28 <input type="checkbox"/>	29 <input type="checkbox"/>	30 <input type="checkbox"/>	31 <input type="checkbox"/>
Day of Week:																
Time Arrived:																
Time Left:																
Total Hours:																
Member's Initials:																

Personal Care Tasks

Bath:																
Skin Care:																
Hair:																
Mouth Care:																
Dressing:																
Ambulation:																
Transfer:																
Toileting:																
Positioning: Turn Every ____ Hour(s) Up in Chair ___ per day																
Prompt to take Medication																
Meals: <input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> D <input type="checkbox"/> Snacks ___ # Diet Special Directions:																
List Essential Errands:																
List Community Activities:																

