



Client Intake Assessment Form
PLAN OF CARE

Client Information

Name: (Last) _____ (First) _____

Gender: F M Age ____ Date of Birth: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Client Lives: Alone With Family Language: _____

Allergies (Specify): _____

Emergency Contacts:

1) _____ Phone: _____ Cell: _____

2) _____ Phone: _____ Cell: _____

SAFETY PRECAUTIONS FOLLOWED: Fall ____ Seizure ____ Bleeding ____ Aspiration ____

Wandering ____ Oxygen ____ Other _____ Comments _____

NEEDS/REQUIREMENTS

PERSONAL CARE

<input type="checkbox"/> Grooming <input type="checkbox"/> Dressing <input type="checkbox"/> Shave/Shampoo <input type="checkbox"/> Oral Care <input type="checkbox"/> Denture Care	<input type="checkbox"/> Skin Care <input type="checkbox"/> Bathing <input type="checkbox"/> Perineal Care <input type="checkbox"/> Showering <input type="checkbox"/> Foot Care <input type="checkbox"/> Nail Care (Do not cut)	<input type="checkbox"/> Remove/Apply Elastic Hose <input type="checkbox"/> Other: _____
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ELIMINATION

<input type="checkbox"/> Bathroom Assistance <input type="checkbox"/> Bedpan/Urinal <input type="checkbox"/> Colostomy Care	<input type="checkbox"/> Ostomy Care <input type="checkbox"/> Incontinence Care <input type="checkbox"/> Catheter Care	<input type="checkbox"/> Empty Drainage Bag <input type="checkbox"/> Record Input & Output <input type="checkbox"/> Other
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NOTES

Our Services are Tailored to Meet the Client's Needs



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NUTRITION

- | | | |
|---|---|--|
| <input type="checkbox"/> Diet
<input type="checkbox"/> Food Allergies
<input type="checkbox"/> Fluid Restriction
<input type="checkbox"/> Enc Fluids | <input type="checkbox"/> Prepare Meals
<input type="checkbox"/> Breakfast
<input type="checkbox"/> AM Snack
<input type="checkbox"/> Lunch | <input type="checkbox"/> PM Snack
<input type="checkbox"/> Dinner
<input type="checkbox"/> Bedtime Snack |
|---|---|--|

Notes:

Special Diet Instructions: _____

HOUSEHOLD MAINTENANCE

- | | |
|---|--|
| <input type="checkbox"/> General Clean Up:
<input type="checkbox"/> Kitchen
<input type="checkbox"/> Bathroom
<input type="checkbox"/> Bedroom
<input type="checkbox"/> Living Room | <input type="checkbox"/> Change Linen q
<input type="checkbox"/> Change PRN (soiled)
<input type="checkbox"/> Grocery Shopping (Do not Handle Cash)
<input type="checkbox"/> Transportation (in patient's vehicle only) |
| <input type="checkbox"/> Laundry
<input type="checkbox"/> Make Bed
<input type="checkbox"/> Change Linen | Other:
<input type="checkbox"/> _____

_____ |

MEDICAL AIDES USED

- | | | |
|--|---|--|
| <input type="checkbox"/> Bedridden
<input type="checkbox"/> Oxygen
<input type="checkbox"/> Walker
<input type="checkbox"/> Hoyer Lift
<input type="checkbox"/> Wheelchair | <input type="checkbox"/> Tube Feeding
<input type="checkbox"/> Ventilator
<input type="checkbox"/> Trapeze
<input type="checkbox"/> Suction Machine
<input type="checkbox"/> Tub Seat | <input type="checkbox"/> Commode
<input type="checkbox"/> Other (specify)

_____ |
|--|---|--|

TYPE OF CARE REQUESTED

- | | | | |
|--|--|---|------------------------------|
| <input type="checkbox"/> Registered Nurse (RN)
<input type="checkbox"/> Live-in | <input type="checkbox"/> LPN
<input type="checkbox"/> Companion | <input type="checkbox"/> CNA
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> HHA |
|--|--|---|------------------------------|

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Notes:

ACTIVITIES

- Complete bed rest Bed rest BRP Up as tolerated Transfer bed/chair
- Exercise prescribed Partial weight bearing Independent at home
- Crutches Cane Wheelchair Walker No restrictions

CLIENT'S FUNCTIONAL LIMITATIONS

- Amputation Bowel/bladder Contracture Hearing Paralysis
- Endurance Ambulation Speech Legally blind

CLIENT'S MENTAL STATUS

- Oriented Comatose Forgetful Depressed Disoriented
- Lethargic Agitated Other _____

Prognosis

- Poor Guarded Fair Good Excellent

Communication

☛ Document all Communication with Nurse or Office, use back as necessary

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HOME HEALTH CARE GOALS
Specific goals include the following as applicable:

- Patient/caregiver will be knowledgeable about disease; behaviors needed to manage condition; signs and symptoms of complications; prescribed diet; signs and symptoms of an emergency and know appropriate actions.
- Patient/caregiver will demonstrate proper administration of medication.
- Patient/caregiver will identify purpose, dose, schedule, adverse effects, and contraindications of prescribed medication.
- Patient/caregiver will demonstrate treatment as prescribed.
- Wound will show signs of healing.
- Patient will report a decrease in pain.
- Patient will increase participation in ADLs.

Date to begin Services _____

Time: _____

Assessment Completed by: _____

Patient or Responsible Party Signature: _____

DHW Caregiver Assigned: _____



12956 Clarksburg Square Road
Clarksburg, MD 20871
Tel: (301) 534-3431 ■ Fax: (301) 515-7093
24hr. Emergency Telephone - (301) 605-4310
www.dedicatedhomeworkersUSA.com

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