Mi Casa Home Health
9301 Indian School Road NE
Suite 208-C
Albuquerque, NM 87112

Assessment and Care Plan

Client_____DOB_____

Address_____Phone_____

Emergency Contact _____Phone_____

POA or Guardian _____ Phone_____

Primary Physician_____ Phone_____ Fax_____

Address_____

Pharmacy Location_____Phone_____

DNR ☐No ☐Yes Level of Care (1)(2)(3)

Care Needs:

Level 1

- ☐ Companionship
- ☐ Cooking/Meal Preparation
- ☐ Light Housekeeping
- ☐ Out of Home Activities
- ☐ Car Transportation
- ☐ Dr. Appt./Errands/Shopping
- ☐ Light Exercise
- ☐ Monitor/Wandering
- ☐ Med Reminders

Level 2

- ☐ Feed
- ☐ Bath/Shower/Sponge
- ☐ Dress/Groom
- ☐ Ambulation
- ☐ Cane/Walker/WhChair/Scooter
- ☐ Toileting
- ☐ Gait
- ☐ Fall Risk

Level 3

- ☐ Feeding Tube
- ☐ Transfers
- ☐ Hoyer
- ☐ Wears Briefs ☐ For Accidents
- ☐ Colostomy
- ☐ Dementia
- ☐ Wound Care
- ☐ Hospice Care
- ☐ Bedbound

Initial Contact: _____ Start Date: _____

Care Goals:

Proposed Schedule:

- ☐ Live In Care Required
- ☐ CNA Required
- ☐ HHA Required
- ☐ LVN / LPN Required
- ☐ RN Required

Caregiver Gender Preference: _____

Demographics:

Date of Birth: _____ Height: _____ Weight: _____

Gender: _____

Marital Status: _____ Spouse Name: _____

Lives With: _____ Religion: _____

Attends Services: _____

DNR: ○ Yes ○ No Languages: _____

Past Profession: _____

Activities of Daily Living (ADLs)

Activities and associated caregiver tasks

Instrumental Activities of Daily Living (IADLs)

Activities and associated caregiver tasks

Medical Conditions:

List any chronic or acute conditions as well as recent hospital/skilled nursing stays:

Hearing: ○ Good ○ Poor ○ Deaf ☐ Hearing aid

Speech: ○ Good ○ Poor ○ None

Vision: ○ Good ○ Poor ○ Blind ☐ Glasses

Swallowing: ○ Good ○ Poor ○ None

Other: ☐ Smoker ☐ Sensitive to smell ☐ On oxygen ☐ Colostomy bag ☐ Feeding tube

Allergies:

Allergies: _____

Notes:

Mental/Behavior Conditions:

Diagnosed Disorders / Medications:

☐ Depression ☐ Lethargy ☐ Past/Current Substance Abuse

Can client be left alone?: _____ Wanderer?: _____ Dementia: _____

Symptoms:

☐ Frequent mood changes	☐ Hallucinations	☐ Problem solving
☐ Short term memory loss	☐ Completing tasks	☐ Sundowning
☐ Spatial/visual relationships	☐ Misplacing items	☐ Poor eating
☐ Speaking/conversing	☐ Poor judgment	☐ Sleeping problems
☐ Anxiety	☐ Agitation	☐ Fear
☐ Paranoia	☐ Suspicion	☐ Aggression
☐ Confusion of time/place	☐ Withdrawal	☐ Depression
☐ Repetition	☐ Wandering	

Triggers:

Elimination:

Incontinence: ☐ Urination ☐ Bowels Wears briefs: _____

Issues: ☐ Constipation ☐ Diarrhea ☐ Urination

Notes:

Ambulation:

Aids: ☐ Cane ☐ Walker ☐ Wheel chair ☐ Geri-chair ☐ Scooter

Fall Risk: ○ Fall Risk ○ No History ○ Poor Balance Use of Arms/Hands: ☐ Left ☐ Right

Notes:

Transfers:

Transfer Types: _____

Aids: ☐ Gait belt ☐ Hoyer ☐ Other: _____

Transfer Risks: _____

Notes:

Bathing, Grooming & Dressing:

☐ Resists Bathing ☐ Uses Shower Bench

Method: ☐ Shower ☐ Bath ☐ Sponge bath Frequency: _____

Hygiene: ☐ Dental/dentures care ☐ Skin care ☐ Other: _____

Dressing: _____

Notes:

Meals:

Assistance: ☐ Cooking ☐ Preparation ☐ Feeding Appetite: _____

Diet: _____

Special diet: _____

Shopping by: _____

Times: ☐ Breakfast _____ ☐ Lunch _____ ☐ Dinner _____ ☐ Snacks _____

Other: ☐ Swallowing issues ☐ Encourage liquids

Favorite Foods: Breakfast: _____

Lunch: _____

Snack: _____

Dinner: _____

Notes:

Driving:

Vehicle: ☐ Client drives ☐ Needs caregiver to drive _____

Other: ☐ Errands: _____ ☐ Doctor's Appointment(s):

_____

Notes:

Exercise:

Importance: _____ ☐ Does client have specific exercise/rehab regimen? ☐ Encourage exercises?

Notes:

Sleep Patterns:

Goes To Bed: _____ Wakes Up: _____

○ Sleeps through night ○ Frequently awakens ○ Gets up for toileting ☐ Difficulty returning to sleep

☐ Needs assistance at night from caregiver? ☐ Naps during day: Time: _____ Duration: _____

Notes:

Equipment/Environment:

Has safety assessment been done? _____ Interested in Lifeline?: _____

☐ Bedrails ☐ Hospital Bed ☐ Bed Commode ☐ Grab Bars

☐ Lift Chair ☐ Raised Toilet Seat ☐ Shower Bench ☐ Handheld Showerhead

☐ Other: _____

Notes:

Pet Care:

☐ Cat ☐ Cat Litter Box ☐ Dog ☐ Feeding ☐ Walk Dog

☐ Other: _____

Notes:

Daily Routine:

Daily Routine

Morning:

Afternoon:

Evening:

Activities

Activities at home:

Activities away from home:

Favorite Restaurants/Shops:

Family/Friends/Neighbors:

Comments

Administrator's Signature Date

Services Coordinator's Signature Date

For Medically Directed Clients: By signing below, I certify that this patient is under my care, and I have authorized and approve the services on this plan of care and will periodically review the plan.

Attending Physician's Signature (if necessary) Date

HHA Nurse's Signature (if necessary) Date