PLAN OF CARE USING UNLICENSED PROXY CAREGIVERS TO PERFORM HEALTH MAINTENANCE ACTIVITIES

1. Client's Claim No.	2. Start of Care Date: _____ 3. Date of this Assessment:: _____	4. Initial training date_____ 5. Frequency of Skill Recheck:_____ 6. Date of Annual Reevaluation of Skills Check Unless Change In Condition:_____	7. Medical Record Number 8. Provider Number:

9. Client's Name, Address, and Telephone Number	10. Provider's Name, Address, and Telephone Number

11. Date of Birth:	12. Sex ☐ M ☐ F	13. Medications: Dose/Frequency/Route (N)New (C)Changed-List or Attach List or MAR.
14. Principal Diagnosis and ICD & date if required		
15. Surgical Procedures and ICD & date if required		
16. Other Pertinent Diagnoses and ICD if required		Vital Signs: BP_____ HR_____Resp_____Temp____ Treatments:

17. DME and Supplies & Equipment:	18 Safety Measures: Universal Precautions, Infection Control, and Protect from Physical Injury.
19. Diet or Nutritional Requirements:	20. Allergies:

21. A. Functional/Physical Limitations		22. B. Activities Permitted	
☐ Amputee	☐ Dressing/Groom Asst _____		☐ Up as Tolerated
☐ Legally Blind	☐ Contractures	☐ Complete Bedrest	☐ Crutches
☐ Bowel/Bladder (Incontinence)	☐ Ambulation	☐ Partial Weight Bearing	☐ No Restrictions
☐ Endurance	☐ Hearing	☐ Wheelchair	☐ Transfer Bed/Chair
☐ Dyspnea with minimal exertion	☐ Paralysis	☐ Bedrest BRP	☐ Cane
☐ Swallowing difficulty	☐ Bathing Asst_____	☐ Independent at Home	☐ Exercises Prescribed
☐ Ambulatory asst._____	☐ Speech_____	☐ Walker	☐Other_____
☐ Other (Specify)_____	☐ No limitations		

23. Mental/Cognitive Status: … ☐ Oriented ☐ Forgetful ☐ Disoriented ☐ Agitated ☐ Memory Impairment
☐ Lacks decision-making capacity regarding medical treatment or ability to communicate such decisions by any means
☐ Comatose ☐ Depressed ☐ Lethargic ☐ Other_____

24. Stability: ☐ Stable ☐ Medically Frail ☐ Medically Compromised
☐ Health Maintenance Activities listed may be performed by properly trained unlicensed caregivers with consent

25. Health Maintenance Activity, Frequency of the Activity, Duration and any special adaptations if applicable.

26. Goals and Objectives:

27. Nurse's Signature and Date of Training	28. Discharge Plans:
29. Physician's Name, Address, Telephone and Fax Number:	30. I recommend the care and services as prescribed and listed above for my patient who is living at home or in a community-based setting. I understand that the patient has consented to having the health maintenance activities listed above performed by properly trained unlicensed proxy caregivers.
31. Physician's, A.P.R.N.'s or P.A.'s Signature:	32. Date Signed: