Comfortcare Homehealth Services LLC

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"Professional staff providing you with quality care"

PAS Initial Eval / Attendant Service Plan / Weekly Attendant Visit Note

AM: PM: Live In Shift: _____

Client Name:_____ Phone:_____ DOB:_____ Date:_____

Address:_____ Service to be provided at:_____

Supervision Frequency:Y_____ Other:_____

Physician:_____ Phone #:_____ Emergency Contact:_____

Relationship:_____ Phone #:_____ Referral Source:_____ Client Diagnosis:_____

Medical/History:_____

Drug and Food Allergies:_____

Type of Service: Y Personal Care O Homemaker Y Companion/Sitter O Respite O transportation

Date of Service Begins:_____ Days and Time: _____

SAFETY AND OTHER PERTINENT INFORMATION - Check all that apply

O Lives alone	O Hard of hearing	O Hearing aid	**Environment**
Y Lives with others	O Dentures O Upper O Lower O Partial		O Inadequate plumbing
O Alone during the day	Y Oriented Y Alert		O Inadequate heat/cooling
O Bad bound	O Forgetful O Confused		O Inadequate refrigeration
O Up as tolerated	O Urinary catheter O Ostomy		O Pest/Rodent infested
O Amputee (specify)	O Artificial limb (specify)		O Animals
O Speech problem	O Diabetic		O Supplies
Y Glasses O Contacts	Y Diet: Liquid or, Puree		Y Special equipment - Wheelchair
O Other vision problem:			
O Other:			

Activities to Provide Check all that apply	Check Frequency to provide Services	Saturday	Sunday	Monday	Tuesday	Wed.	Thurs.	Friday	
Time In									
Time Out									
O Bath O Bed Y Shower O Tub	O CV Y CC O A								
O Shampoo O Hair care/comb/brush	O CV Y CC O A								
O Oral hygiene/care	O CV Y CC O A								
O Assist with ambulation	O CV Y CC O A								
O Assist with meds	O CV Y CC O A								
Y Transfers	O CV Y CC O A								
Y Use of assistive devices	O CV Y CC O A								
Type : Wheelchair									
O Meal Preparation	O CV Y CC O A								
Diet:									
Y Assist with Feeding	O CV Y CC O A								
Y Toileting	O CV Y CC O A								
O Transportation	O CV Y CC O A								
O Change/wash linens/make bed	O CV Y CC O A								
O Light Housekeeping	O CV Y CC O A								
Y Standard Precautions/Safety Measures	O CV Y CC O A								
Y Shop/errands - as needed	O CV Y CC O A								
Y Assist with Company/Visitors	O CV Y CC O A								

KEY: QV = every visit **CC - Caregiver/Client choice A = Assist**

Comments:_____

O See delegation sheet for:_____

Attendant Name: (print)_____

Employee Signature:_____ Date:_____