

CLIENT SERVICE INFORMATION

Client Goal for Service _____

Hearing: _____ Aids: L R Vision : _____ Glasses: Yes NoContinent: Bowel Yes No Bladder Yes No Continance Pad Yes No

Mobility Independent Supervised (Stand By) Verbal Cueing Minimal Assist (1 Person Transfer)
 Moderate Assist (1-2 Persons &/or Device) Dependent (No Manual Transfer)

Equipment Wheelchair Scooter Walker Canes
 Other (list): _____

Personal Assistance Bath Shave Transferring Dressing
 Bed bath Shampoo Repositioning Perineal Care
 Sponge bath Skincare Walking Toileting
 Cueing/Coaching: _____ Other: _____

Delegation of Tasks:

General Cleaning Kitchen Laundry Bed Change Vacuum
 Bathroom Shopping Wash Floor Dusting
 Other: _____

Periodic Cleaning Oven Fridge Inside Windows

Meal Preparation: _____**Diet Instructions (Including Allergies):** _____

Community Support Adult Day Care Home Care Nurse Mental Health Worker Other:
 Handidart Lifeline Rehabilitation Therapist
 Nutritionist Hospice Meals on Wheels

Does the Community Health Worker provide childcare? Yes No

Children's names:

1) _____ DOB _____ Allergies _____

2) _____ DOB _____ Allergies _____

3) _____ DOB _____ Allergies _____

Unauthorized visitors: _____

Other information: _____**Comments:**Copies to: Area Scheduler RN/CC/LPN Accounting Other: _____