MONTHLY CARE PLAN REPORT

Residents Name:	Date:
Facility:	Prepared by:

PERIOD	WEIGHT (LBS)	BLOOD PRESSURE	PULSE
WEEK 1			
WEEK 2			
WEEK 3			
WEEK 4			

ORIENTATION:		
NEEDS REDIRECTION	NEEDS CUEING	NO SERVICES NEEDED:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

BEHAVIOR MANAGEMENT:		
SLEEPS WELL	WAKES UP DURING NIGHT	WANDERS AT NIGHT
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
CALLS OUT AT NIGHT	WANDERS	RESISTANCE TO CARE
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
AGITATED-VERBAL	AGITATED-PHYSICAL	RESTLESS:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
SOMETIMES IS AGITATED	SHOWS SIGNS OF DEPRESSION:	
☐ Yes ☐ No	☐ Yes ☐ No	

SOCIALIZATION AND ACTIVITIES:		
NEEDS ENCOURAGEMENT	OUTINGS	EXERCISE
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
KARAOKE	ARTS & CRAFTS	GAMES
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
MUSIC THERAPY	NO SERVICE NEEDED	
☐ Yes ☐ No	☐ Yes ☐ No	

PERIOD	MUSIC THERAPY %	EXERCISE %	ARTS & CRAFTS %	OUTINGS %
WEEK 1				
WEEK 2				
WEEK 3				
WEEK 4				

CONTINENCE:		
BOWEL	BLADDER	VERBAL
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
REMINDERS NEEDED	TOILETING SCHEDULE	BEDSIDE COMMODE
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
INDEPENDENT	ASSISTANCE NEEDED	NO SERVICE NEEDED
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Residents Name:	Date:

U.T.I/DIPSTICK RESULTS:		
TESTED FOR UTI	POSITIVE RESULTS	NEGATIVE RESULTS
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Details:		

MEDICATIONS:	
CHANGES IN MEDICATIONS?	Please list:
☐ Yes ☐ No	

BATHING:		
SHOWERS	ASSISTED BY CAREGIVER	SPECIAL PLAN OF CARE
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
FREQUENCY OF WEEKLY SHOWERS ____________________ ____________________	DAYS OF THE WEEK: ____________________ ____________________	ANY SPECIAL NEEDS: ☐ Yes ☐ No
SHOWS RESISTANCE	Comments:	
☐ Yes ☐ No		

DRESSING:		
TOTAL ASSIST	SPECIAL GARMENTS	ASSISTS WITH UPPER BODY
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ASSISTS WITH LOWER BODY	BUTTONS	ZIPPERS
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
SOCKS AND SHOES	ANY SPECIAL NEEDS:	Please list:
☐ Yes ☐ No	☐ Yes ☐ No	

GROOMING/PERSONAL HYGIENE:		
ASSIST	CUEING	TOTAL ASSIST
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
APPLIES MAKEUP	BEAUTY TIME	ORAL CARE AM
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ORAL CARE PM	NAIL CARE/MANICURE BY STAFF	NAIL CARE PODIATRIST
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

MOBILITY:		
USES A WALKER	WHEELCHAIR	TRANSFER ASSIST
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ESCORTED TO MEALS	WEAKNESS	TREMORS LEFT/RIGHT SIDE
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No L R (CIRCLE)
AMBULATION PROGRAM	NO SERVICE NEEDED	
☐ Yes ☐ No PT/OT (CIRCLE)	☐ Yes ☐ No	

Residents Name:	Date:

COMMUNICATION:		
WEARS GLASSES	HEARING AIDS	DENTURES
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
NO SERVICE NEEDED		
☐ Yes ☐ No		

DINING/MEALS/SNACKS:		
EATS IN DINING ROOM	EATS IN BEDROOM	CUEING
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
MONITOR FOOD INTAKE	FOOD CUT INTO SMALL PIECES	PUREE DIET
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DIABETIC DIET	FLUID INTAKE/GLASSES PER DAY	% OF FOOD INTAKE/MEALS PER DAY
☐ Yes ☐ No PT/OT (CIRCLE)	___________________________	__________________________
MONITOR INTAKE	SPECIAL REQUESTS	NO SPECIAL SERVICE NEEDED
☐ Yes ☐ No	___________________________________	☐ Yes ☐ No

FLUID INTAKE:	
GLASS OF FLUIDS EACH DAY	
SNACKS OFFERED AND HOW OFTEN	☐ Yes ☐ No

% AMOUNT OF MEALS CONSUMED	WEEK 1	WEEK 2	WEEK 3	WEEK 4
BREAKFAST				
LUNCH				
DINNER				

Service and Care Plan Follow up and updates from previous month:

Special circumstances or changes in care plan:	Care Plan additions or changes:
____ ____ ____ ____ ____ ____	_________________________ _________________________ _________________________ _________________________ __________________________ __________________________