



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:
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

BEHAVIOR MANAGEMENT:		
SLEEPS WELL	WAKES UP DURING NIGHT	WANDERS AT NIGHT
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
CALLS OUT AT NIGHT	WANDERS	RESISTANCE TO CARE
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
AGITATED-VERBAL	AGITATED-PHYSICAL	RESTLESS:
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
SOMETIMES IS AGITATED	SHOWS SIGNS OF DEPRESSION:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SOCIALIZATION AND ACTIVITIES:		
NEEDS ENCOURAGEMENT	OUTINGS	EXERCISE
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
KARAOKE	ARTS & CRAFTS	GAMES
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
MUSIC THERAPY	NO SERVICE NEEDED	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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

CONTINENCE:		
BOWEL	BLADDER	VERBAL
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
REMINDERS NEEDED	TOILETING SCHEDULE	BEDSIDE COMMODE
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
INDEPENDENT	ASSISTANCE NEEDED	NO SERVICE NEEDED
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Residents Name:	Date:
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U.T.I/DIPSTICK RESULTS:		
TESTED FOR UTI	POSITIVE RESULTS	NEGATIVE RESULTS
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Details:		

MEDICATIONS:	
CHANGES IN MEDICATIONS?	Please list:
<input type="checkbox"/> Yes <input type="checkbox"/> No	

BATHING:		
SHOWERS	ASSISTED BY CAREGIVER	SPECIAL PLAN OF CARE
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
FREQUENCY OF WEEKLY SHOWERS	DAYS OF THE WEEK:	ANY SPECIAL NEEDS:
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	
SHOWS RESISTANCE	Comments:	
<input type="checkbox"/> Yes <input type="checkbox"/> No		

DRESSING:		
TOTAL ASSIST	SPECIAL GARMENTS	ASSISTS WITH UPPER BODY
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
ASSISTS WITH LOWER BODY	BUTTONS	ZIPPERS
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
SOCKS AND SHOES	ANY SPECIAL NEEDS:	Please list:
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

GROOMING/PERSONAL HYGIENE:		
ASSIST	CUEING	TOTAL ASSIST
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
APPLIES MAKEUP	BEAUTY TIME	ORAL CARE AM
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
ORAL CARE PM	NAIL CARE/MANICURE BY STAFF	NAIL CARE PODIATRIST
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

MOBILITY:		
USES A WALKER	WHEELCHAIR	TRANSFER ASSIST
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
ESCORTED TO MEALS	WEAKNESS	TREMORS LEFT/RIGHT SIDE
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No L R (CIRCLE)
AMBULATION PROGRAM	NO SERVICE NEEDED	
<input type="checkbox"/> Yes <input type="checkbox"/> No PT/OT (CIRCLE)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

