

Local Department: _____
Client's Name: _____

**IHAS CARE PLAN
PERSONAL CARE PLAN**
(TO BE COMPLETED BY A REGISTERED NURSE OR DOCTOR)
(CHECK APPLICABLE ITEMS)

| SECTION | A | A/C | C | V** | COMMENTS |
|--|---|-----|---|-----|----------|
| 1. Bath – Bed | | | | | |
| 2. Bath – Chair | | | | | |
| 3. Hair – Comb | | | | | |
| 4. Hair – Shampoo | | | | | |
| 5. Mouth Care/Denture Care | | | | | |
| 6. Fingernails – clean | | | | | |
| 7. Fingernails – File _____ Cut _____ | | | | | |
| 8. Toenails – Clean | | | | | |
| 9. Toenails – File _____ Cut _____ | | | | | |
| 10. Shave* | | | | | |
| 11. Help with Toileting | | | | | |
| 12. Help with Dressing | | | | | |
| 13. Help with Walking | | | | | |
| 14. Help with Feeding | | | | | |
| 15. Change Position | | | | | |
| 16. Simple Range of Motion | | | | | |
| 17. Transfer | | | | | |
| 18. Urge Fluids | | | | | |
| 19. Special Skin care or Dressing Specify in "Comments" | | | | | |
| 20. Measure Intake and Output | | | | | |
| 21. Observe Medications | | | | | |
| 22. Other: | | | | | |
| 23. Other: | | | | | |

Is In-Home demonstration necessary for an aide to safely perform any of the personal care activities checked above?

Yes _____ Numbers _____ No _____

When should the client's need for personal care be reevaluated _____
(No more than 6 months from date of this assessment)

Special precautions/comments: _____

Nurse or physician's signature _____

Date Phone #

*Physician's signature required _____

Date Phone #

Agency _____

TO BE COMPLETED BY THE IHAS

Plan for periodic nursing supervision _____

Date of in home demonstration by nurse if necessary

**Explanation of Code
A=Function performed mostly by Aide
A/C = Function performed jointly by Aide and Client
C= Function performed mostly by Client
V= Volunteer Assistance