

STATE OF OKLAHOMA
DEPARTMENT OF HUMAN SERVICES
PERSONAL CARE PROGRESS NOTES

Date to: _____
Agency _____
File _____

Client name	Case number	County
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Routine follow-up visit Case management visit Recertification visit

Long-term care (LTC) nurse signature

Date

FOLLOW-UP VISIT. OAC 317:35-15-8, made for purpose of assessing client's satisfaction with care AND adequacy of goals and units allotted. Nursing judgment is based upon Form AG-2, Parts I, II, and III, Uniform Comprehensive Assessment, (UCAT).

Health conditions: Unchanged Improved Deteriorated

Comments: _____

New medications:

Name	Dosage	Frequency	Physician	Date filled

Date of last physician visit: _____ Physician name: _____

Has client been treated in the **E.R. or the** **hospital since the last visit?** Yes No

Comments: _____

Has client experienced a significant weight change in last six months? Yes No

Weight: _____ Gain/Loss attributed to: _____

Current diet: _____

Nutritional supplements used: Yes No

Name/quantity/frequency _____

Home delivered meals: Yes No Agency/frequency: _____

Condition of skin: _____ Peripheral edema: _____

Visible sites: Bruise Cuts Decubitus/lesions Rash Incision
 Other _____ Location of site: _____

Comments: _____

Mental status: Oriented Confused Forgetful Anxious Lethargic
 Depressed Comatose Other _____

Comments: _____

ADL functions: Unchanged Poor Fair Improved

IADL functions: Unchanged Poor Fair Improved

Comments: _____

Safety issues: Yes No Comments: _____

CLIENT COMMUNICATION.

Client rating of own health: Poor Fair Good Excellent

Comments: _____

Informal support: Inadequate Adequate Primary caregiver: _____
 What do they do to assist you and how often? _____

Formal support: Home health Hospice VA aide Indian health Adult day care
 Primary caregiver: _____
 What do they do to assist you and how often? _____

Personal Care services:

Can you tell me the name of your personal care aide (PCA)? Yes No
 Name: _____

Is the PCA related to you? Yes No Relation: _____

Your PCA works for what agency? _____

Does your PCA arrive on time? Yes No Stay the allotted time? Yes No

Comments: _____

When PCA is unable to make your regular visit, does the agency send someone else? Yes No

Comments: _____

√	Check task designated on care plan	Frequency reported by client							Client comments
		M	T	W	T	F	S	S	
	Bathing								
	Grooming								
	Hair care								
	Ambulation								
	Meal preparation								
	Laundry								
	Housekeeping								
	Errands/shopping								
	Other								
	Daily totals								= _____ units/wk # authorized/wk _____

No change needed Reassignment of units Decrease units Increase units

Increase of 16 units per week or more require reassessment

Service plan change needed: Yes No New service plan required for all changes in units

Community potential rating: No potential Low Moderate High

Scheduled frequency of follow-up visit: _____

Copy of care plan and service plan in the home: Yes No

TEACHING/INSTRUCTIONS:

CASE MANAGEMENT VISIT:

Reason for visit: Change in condition Problem or complaint Request for changes Other

Issue/interventions: