Name of Patient: ___________________________________________ Date: ___________

**Functional Needs (Circle):**
- Bathing
- Grooming
- Dressing
- Eating
- Transferring
- Patient/client independent in ADL's / IADL's

**Reason for Visit:**
- Medication management
- Other:
- Other:

**Medication management [ ]** 
- Tolerating medications without side effects or adverse reactions
- Patient will follow with physician as instructed

**Caregiver independent with: [ ]**
- Wound care
- IV therapy
- Medication management
- Wound/ incision healing without complications

**Interventions/Instructions:**
- Teaching/training re: [ ]
- Disease process [ ]
- Bleeding precautions [ ]
- Wound/incipient care [ ]
- IV therapy [ ]
- Infection control measures [ ]
- Complications to report [ ]
- Physician follow up [ ]
- Home safety [ ]
- Oxygen safety [ ]
- Diet [ ]
- Elevating legs to decrease edema [ ]
- Off loading techniques [ ]
- Sharps disposal [ ]
- Plan of care review [ ]
- Medication management [ ]
- Ability to void post Foley removal [ ]
- Discharge instructions [ ]

**Wound Care Performed:**
- Aseptic technique [ ]
- Sterile technique [ ]
- Cleansed with NS [ ]
- Cleansed with: ________________________________________

**Interventions:**
- Administered: _____________________________ [ ]
- IM [ ]
- SQ Site: __________________
- Site: __________________
- Pt/CG taught to administer: ___________________________

**Bowel Bladder:**
- Foley catheter inserted ________ Fr cc balloon using sterile technique with ________ return
- Connected to [ ]
- Bedside drainage bag [ ]
- Foley removed without incident [ ]
- Instructions given regarding complications to report [ ]
- Bowl program performed [ ]
- Suppository used [ ]
- Digital stimulation Results: __________________

**Perforates Care Properly:**
- Yes [ ]
- No [ ]
- Patient satisfied [ ]
- Yes [ ]
- No [ ]
- HHA Present [ ]
- Yes [ ]
- No [ ]

**Other:**
- See communication sheet for addendum notes

**Patient/Designee:**
- I certify that the Matrix Home Care Employee listed on this note worked the times indicated and the work was performed in a satisfactory manner. I agree to the times regarding this slip. Time in: ________ [ ] am [ ] pm Time out: ________ [ ] am [ ] pm

**Patient Signature:** ___________________________________________ Date: ___________

**Caregiver signature/title:** ___________________________________________ Date: ___________
Patient/Client Name: 

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