<table>
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<th><strong>HOSPICE AIDE PLAN OF CARE</strong></th>
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<td>Rev 07/18</td>
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Patient’s Address ____________________________ Age: ______

Hospice Case Manager ____________________________ Telephone: __________________

Goals _______________________________________ Scheduled Hours: ____________________

DNR □ Yes □ No Location of Form: ____________________________________________

Health Care Proxy: □ Yes □ No Location of Form: ____________________________________

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<th><strong>DATE</strong> (Day/Month/Year)</th>
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**Vital Signs:**
- □ Temperature □ Pulse □ Respirations

**Meds**
- □ Prompt □ Assists

**Treatment**
- Catheter Care
- Ostomy Care
- Medical Supplies
- Dressings
- □ Incontinent □ Toilet □ Commode □ Bedpan

**Personal Care:**
- □ Bed bath □ Shower □ Tub
- Shampoo Hair
- Comb Hair
- Shave
- Foot Bath
- Nail Care
- Skin Care
- Mouth care

**Exercise/Activity:**
- Ambulation with assist
- Transfer
- Turn/Position
- Range of Motion
- OT/ST/PT Program
- Shopping/Errands/Clean Living Area

**Nutrition**
- Meal Preparation
- □ Breakfast □ Lunch □ Dinner
- Special diet
- Assist Feeding

**Nurse’s Signature and Title/INITIALS:**