Company Name
Companion Service Plan

Client Name:_____ D.O.B.:_____ Phone:_____
Address:_____
Lives Alone: ☐ Yes ☐ No With_____ Emergency Contact :_____
Primary Diagnosis:_____ Emergency #:_____
Allergies: _____ Vehicle to be Used: ☐ Contractor ☐ Client
Physician's #:_____ Med Box____ Petty Cash_____

☐ W/C ☐ Bed ☐ Walker ☐ Cane ☐ BSC ☐ Oxygen ☐ Home Monitoring ☐ Other: _____
Functional Limitations: ☐ Visual Impairment ☐ HOH ☐ Speech ☐ Ambulation

CLIENT ASSISTANCE	HOUSEHOLD SERVICES
Interaction with client limited/encouraged	Change Linen Make Bed Laundry Iron
Talk With Client Transportation/Errands	Light Housekeeping: Client Area/Bedroom Bathroom Living Rm
Assist With Hobbies Read To Client	Dust Vacuum Damp-Mop Clean Kitchen
Personal Care: Independent / Remind / Stand-by	Wash Dishes Check Food In Refrigerator Empty Trash
NUTRITION AND DIETARY	Other:
Prepare Food Serve Food	**FREQUENCY**
Breakfast Lunch Dinner Snacks	**SUN MON TUE WED THU FRI SAT**
Encourage/Restrict Fluids Special Diet Purchase Food Notes:	**Dates:** **Hours**
DNR	**PRECAUTIONS**
Yes No Copy Obtained	Seizure Precautions Fall Prone High Risk Meds
ADVANCE DIRECTIVE	Constant Monitoring Aspiration Anxiety
Yes No Copy Obtained	Other:

Special Instructions: _____

_____

_____

_____

_____

Delegated Task will be Supervised by**:** Check All That Apply

☐ Client ☐ Responsible party/family member ☐ Agency Companion Supervisor ☐ PAS Supervisor

If there is any change in the client's condition or status or if the client is hospitalized for any amount of time it is imperative that you call the agency at 555-555-5555.