

HCAB

Home Care Agency Blueprint

Building Successful Home Care Businesses

## Care Plan

## Templates

Professional Client Care Planning Documents

Complete Bundle

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Care Plan Templates

10-Pack Professional Collection

Comprehensive, ready-to-use care plan templates designed specifically for home care agencies. Each template includes client information, assessments, goals, interventions, schedules, and review sections to ensure quality, consistent care delivery.

Professional Templates for Home Care Excellence

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# Table of Contents

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	How to Use These Templates	3
1	General Home Care Plan	4
2	Personal Care / ADL Care Plan	7
3	Companion Care Plan	10
4	Dementia / Alzheimer's Care Plan	13
5	Post-Hospital Discharge Care Plan	16
6	Respite Care Plan	19
7	End-of-Life / Comfort Care Plan	22
8	Diabetic Client Care Plan	25
9	Fall Risk Care Plan	28
10	Mobility / Transfer Care Plan	31

# How to Use These Templates

## 1 Select the Appropriate Template

Choose the care plan template that best matches your client's primary care needs. For clients with multiple conditions, you may combine elements from several templates.

## 2 Complete Client Information

Fill in all client demographic information, emergency contacts, and physician details. Ensure all contact information is current and accurate.

## 3 Conduct Thorough Assessment

Use the assessment section to document the client's current functional status, medical conditions, and care needs. This forms the foundation for the care plan.

## 4 Establish SMART Goals

Set Specific, Measurable, Achievable, Relevant, and Time-bound goals. Involve the client and family in goal-setting when possible.

## 5 Document Interventions

Clearly outline the specific care activities, frequency, and responsible parties. Be detailed enough that any caregiver can follow the plan consistently.

## 6 Create Care Schedule

Develop a weekly schedule that addresses all care needs while respecting client preferences and routines.

## 7 Review and Update Regularly

Care plans should be reviewed at least every 90 days or whenever there's a significant change in the client's condition. Document all updates.

### Best Practice Tip

Keep a copy of the care plan in the client's home for reference by all caregivers. Ensure the client and/or family representative signs acknowledging receipt and agreement with the plan.

## Client Information

CLIENT NAME

DATE OF BIRTH

ADDRESS

PHONE NUMBER

ALTERNATE PHONE

EMAIL

PRIMARY PHYSICIAN

PHYSICIAN PHONE

### Emergency Contacts

CONTACT NAME

RELATIONSHIP

PHONE NUMBER

CONTACT NAME

RELATIONSHIP

PHONE NUMBER

## Assessment

MEDICAL HISTORY / DIAGNOSES

CURRENT MEDICATIONS

ALLERGIES

FUNCTIONAL STATUS ASSESSMENT

Independent

Needs Supervision

Needs Assistance

Dependent

ACTIVITY	INDEPENDENT	SUPERVISION	ASSISTANCE	DEPENDENT
Bathing				
Dressing				

Grooming

Toileting

Mobility

Eating

Medication Reminders

## Care Goals

### 1 Primary Care Goal

GOAL DESCRIPTION

TARGET DATE

MEASURABLE OUTCOME

### 2 Secondary Care Goal

GOAL DESCRIPTION

TARGET DATE

MEASURABLE OUTCOME

### 3 Additional Goal

GOAL DESCRIPTION

TARGET DATE

MEASURABLE OUTCOME

## Interventions / Care Tasks

CARE TASK

FREQUENCY

SPECIAL INSTRUCTIONS

ASSIGNED TO

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## Weekly Care Schedule

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TIME	MON	TUE	WED	THU	FRI	SAT	SUN
Morning							
Midday							
Afternoon							
Evening							
Night							

### CLIENT PREFERENCES AND ROUTINES

### SPECIAL INSTRUCTIONS / NOTES

## Care Plan Review

---

### Review Schedule

PLAN START DATE

NEXT REVIEW DATE

REVIEW FREQUENCY

---

Client / Representative Signature

---

Date

---

Care Coordinator Signature

---

Date

## Client Information

CLIENT NAME

DATE OF BIRTH

ADDRESS

PRIMARY PHYSICIAN

PHYSICIAN PHONE

### Emergency Contact

CONTACT NAME

RELATIONSHIP

PHONE NUMBER

## ADL Assessment

ACTIVITY	CURRENT LEVEL	ASSISTANCE NEEDED	EQUIPMENT USED
Bathing			
Dressing			
Grooming			
Oral Care			
Toileting			
Continence			
Transferring			
Eating			

### SKIN CONDITION

Intact
  Dry
  Fragile
  Pressure Areas
  Wounds
  Rashes

### SKIN NOTES / AREAS OF CONCERN

## Personal Care Goals

## 1 Hygiene Goal

### GOAL DESCRIPTION

### TARGET DATE

### MEASURABLE OUTCOME

## 2 Independence Goal

### GOAL DESCRIPTION

### TARGET DATE

### MEASURABLE OUTCOME

## Personal Care Interventions

### Bathing Routine

#### PREFERRED TIME

#### FREQUENCY

#### TYPE

- Shower  Tub Bath  Bed Bath  Sponge Bath

#### SPECIAL INSTRUCTIONS

CARE TASK	FREQUENCY	SPECIFIC INSTRUCTIONS	CAREGIVER
Hair Care			
Nail Care			
Shaving			
Skin Care			
Dressing Assistance			
Toileting Assistance			

Incontinence Care

## Daily Personal Care Schedule

TIME	MON	TUE	WED	THU	FRI	SAT	SUN
6:00 AM							
8:00 AM							
10:00 AM							
12:00 PM							
2:00 PM							
4:00 PM							
6:00 PM							
8:00 PM							

### CLIENT PREFERENCES

## Care Plan Review

<b>PLAN START DATE</b>	<b>NEXT REVIEW DATE</b>	<b>REVIEW FREQUENCY</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>REVIEW NOTES</b>		
<input type="text"/>		

\_\_\_\_\_  
Client / Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Care Coordinator Signature

\_\_\_\_\_  
Date

## Client Information

CLIENT NAME

DATE OF BIRTH

ADDRESS

PHONE NUMBER

EMAIL

### Emergency Contact

CONTACT NAME

RELATIONSHIP

PHONE NUMBER

## Social and Emotional Assessment

LIVING SITUATION

Lives Alone

Lives with Spouse

Lives with Family

Assisted Living

SOCIAL SUPPORT NETWORK

Strong

Moderate

Limited

Isolated

SIGNS OF SOCIAL ISOLATION

Withdrawal

Loneliness

Depression

Anxiety

Loss of Interest

None Observed

HOBBIES AND INTERESTS

COMMUNICATION ABILITIES

## Companion Care Goals

1

### Social Engagement Goal

GOAL DESCRIPTION

TARGET DATE

MEASURABLE OUTCOME

**2 Emotional Wellbeing Goal**

GOAL DESCRIPTION

TARGET DATE

MEASURABLE OUTCOME

### Companion Care Interventions

ACTIVITY TYPE	FREQUENCY	DETAILS / CLIENT PREFERENCES
Conversation / Socialization		
Reading / Audiobooks		
Games / Puzzles		
TV / Movies		
Crafts / Hobbies		
Walks / Outdoor Time		
Errands / Shopping		
Appointments / Outings		
Phone / Video Calls		
Meal Companionship		

PREFERRED TOPICS OF CONVERSATION

TOPICS / ACTIVITIES TO AVOID

### Weekly Companion Care Schedule

TIME	MON	TUE	WED	THU	FRI	SAT	SUN
------	-----	-----	-----	-----	-----	-----	-----

Morning

Afternoon

Evening

**REGULAR APPOINTMENTS / COMMUNITY ACTIVITIES**

**TRANSPORTATION NEEDS**

**Care Plan Review**

---

**PLAN START DATE**

**NEXT REVIEW DATE**

**REVIEW FREQUENCY**

---

Client / Representative Signature

---

Date

---

Care Coordinator Signature

---

Date

## Client Information

CLIENT NAME

DATE OF BIRTH

ADDRESS

PRIMARY PHYSICIAN

NEUROLOGIST / SPECIALIST

### Emergency Contacts (Multiple Required)

PRIMARY CONTACT

RELATIONSHIP

PHONE NUMBER

SECONDARY CONTACT

RELATIONSHIP

PHONE NUMBER

## Cognitive Assessment

DIAGNOSIS

DATE OF DIAGNOSIS

CURRENT STAGE

Early/Mild

Middle/Moderate

Late/Severe

COGNITIVE SYMPTOMS PRESENT

Memory Loss

Confusion

Disorientation

Difficulty Communicating

Poor Judgment

Wandering

Sundowning

Agitation

Hallucinations

Sleep Disturbances

BEHAVIORAL TRIGGERS

CALMING STRATEGIES THAT WORK

## Safety Assessment

WANDERING RISK

Low
  Moderate
  High

**SAFETY MEASURES IN PLACE**

Door Alarms
  GPS Tracker
  ID Bracelet
  Secured Exits
  Stove Safety
  Medication Lock

**Dementia Care Goals**

**1 Safety Goal**

**GOAL DESCRIPTION**

**TARGET DATE**  **MEASURABLE OUTCOME**

**2 Quality of Life Goal**

**GOAL DESCRIPTION**

**TARGET DATE**  **MEASURABLE OUTCOME**

**Memory Care Interventions**

INTERVENTION	FREQUENCY	SPECIFIC INSTRUCTIONS
Orientation Reminders		
Memory Activities		
Routine Maintenance		
Redirection Techniques		
Validation Therapy		
Music Therapy		
Supervision Level		

**PERSONAL HISTORY / LIFE STORY (FOR REMINISCENCE)**

## Daily Routine Schedule

---

**Important**

Maintaining consistent routines is essential for clients with dementia. Follow this schedule as closely as possible to reduce confusion and anxiety.

TIME	SCHEDULED ACTIVITY
6:00 AM	
7:00 AM	
8:00 AM	
9:00 AM	
10:00 AM	
11:00 AM	
12:00 PM	
1:00 PM	
2:00 PM	
3:00 PM	
4:00 PM	
5:00 PM	
6:00 PM	
7:00 PM	
8:00 PM	

## Care Plan Review

---

**PLAN START DATE**

**NEXT REVIEW DATE**

**REVIEW FREQUENCY**

---

Family / Legal Representative Signature

Date

---

Care Coordinator Signature

Date

## Client Information

---

CLIENT NAME

DATE OF BIRTH

ADDRESS

### Emergency Contact

CONTACT NAME

RELATIONSHIP

PHONE NUMBER

## Hospitalization Information

---

HOSPITAL NAME

DISCHARGE DATE

REASON FOR HOSPITALIZATION

PROCEDURES / SURGERIES PERFORMED

DISCHARGE DIAGNOSIS

## Post-Discharge Assessment

---

ACTIVITY RESTRICTIONS

 No Lifting > 10 lbs No Driving Bed Rest Limited Mobility No Bathing/Showering Limited Stairs

ADDITIONAL RESTRICTIONS

DIETARY RESTRICTIONS

## Medication Management

---

MEDICATION	DOSE	FREQUENCY	PURPOSE	SPECIAL INSTRUCTIONS

### Recovery Goals

**1 Primary Recovery Goal**

GOAL DESCRIPTION

TARGET DATE  MEASURABLE OUTCOME

**2 Functional Recovery Goal**

GOAL DESCRIPTION

TARGET DATE  MEASURABLE OUTCOME

### Post-Discharge Care Interventions

CARE TASK	FREQUENCY	INSTRUCTIONS
Medication Reminders		
Wound Care		
Vital Sign Monitoring		
Mobility Assistance		
Meal Preparation		
Transportation to Appointments		

### Follow-Up Appointments

PROVIDER	DATE	TIME	PURPOSE	LOCATION

**Warning Signs - When to Call the Doctor**

**Call physician immediately if client experiences:**

CALL 911 IF:

**Care Plan Review**

PLAN START DATE	EXPECTED DURATION	NEXT REVIEW DATE
<input type="text"/>	<input type="text"/>	<input type="text"/>

\_\_\_\_\_  
Client / Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Care Coordinator Signature

\_\_\_\_\_  
Date

## Client Information

---

CLIENT NAME

DATE OF BIRTH

ADDRESS

## Primary Caregiver Information

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PRIMARY CAREGIVER NAME

RELATIONSHIP TO CLIENT

PHONE NUMBER

ALTERNATE PHONE

REASON FOR RESPITE CARE

 Vacation / Travel Personal Appointment Caregiver Rest Work Commitment Emergency Regular Scheduled Break

## Respite Schedule

---

START DATE/TIME

END DATE/TIME

RESPITE SCHEDULE TYPE

 One-Time Weekly Bi-Weekly Monthly As Needed

## Client Assessment

---

MEDICAL CONDITIONS / DIAGNOSES

CURRENT MEDICATIONS

ALLERGIES

## Respite Care Goals

---

**1 Client Safety and Comfort Goal**

**GOAL DESCRIPTION**

**2 Caregiver Support Goal**

**GOAL DESCRIPTION**

**Care Interventions During Respite**

CARE TASK	TIME	SPECIAL INSTRUCTIONS
Personal Care		
Medication Reminders		
Meals / Snacks		
Mobility Assistance		
Toileting		
Activities / Engagement		
Rest / Sleep		

**DAILY ROUTINE (AS FOLLOWED BY PRIMARY CAREGIVER)**

**CLIENT PREFERENCES AND COMFORT ITEMS**

**BEHAVIORS TO WATCH FOR / TRIGGERS**

**Care Plan Review**

**PLAN CREATED**

**REVIEW DATE**

**REVIEWED BY**

---

Primary Caregiver Signature

---

Date

---

Respite Caregiver Signature

---

Date

## Client Information

CLIENT NAME

DATE OF BIRTH

ADDRESS

PRIMARY PHYSICIAN

HOSPICE PROVIDER (IF APPLICABLE)

### Family / Healthcare Proxy Contacts

HEALTHCARE PROXY NAME

RELATIONSHIP

PHONE NUMBER

## Advance Directives

DOCUMENTS ON FILE

Living Will

Healthcare Power of Attorney

DNR Order

POLST Form

None on File

CLIENT'S WISHES REGARDING HOSPITALIZATION

RESUSCITATION PREFERENCES

## Comfort Care Assessment

PRIMARY DIAGNOSIS

CURRENT SYMPTOMS

Pain

Shortness of Breath

Nausea

Fatigue

Anxiety

Confusion

Difficulty Swallowing

Skin Breakdown

PAIN ASSESSMENT (IF APPLICABLE)

Pain Level:

0 1 2 3 4 5 6 7 8 9 10

## Comfort Care Goals

**1** **Comfort and Pain Management Goal**

**GOAL DESCRIPTION**

**2** **Dignity and Quality of Life Goal**

**GOAL DESCRIPTION**

**Comfort Care Interventions**

INTERVENTION	FREQUENCY	SPECIAL INSTRUCTIONS
Pain Management		
Positioning/Turning		
Mouth Care		
Skin Care		
Hygiene/Bathing		
Nutrition/Hydration		
Emotional Support		
Spiritual Care		

**CLIENT'S PERSONAL PREFERENCES FOR COMFORT**

**SPIRITUAL / RELIGIOUS PREFERENCES**

**MUSIC, ENVIRONMENT, OR OTHER COMFORT MEASURES**

**Care Plan Review**

**PLAN CREATED**

**REVIEW DATE**

**REVIEWED BY**

---

Family / Healthcare Proxy Signature

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Date

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Care Coordinator Signature

---

Date

## Client Information

---

CLIENT NAME

DATE OF BIRTH

ADDRESS

PRIMARY PHYSICIAN

ENDOCRINOLOGIST (IF APPLICABLE)

### Emergency Contact

CONTACT NAME

RELATIONSHIP

PHONE NUMBER

## Diabetes Assessment

---

DIABETES TYPE

Type 1

Type 2

Gestational

Pre-Diabetes

YEAR DIAGNOSED

TARGET BLOOD GLUCOSE RANGE

LAST A1C RESULT / DATE

DIABETES MANAGEMENT METHOD

Diet Only

Oral Medications

Insulin Injections

Insulin Pump

CGM Monitor

DIABETES COMPLICATIONS PRESENT

Neuropathy

Retinopathy

Nephropathy

Cardiovascular

Foot Problems

None

## Diabetes Management Goals

---

## 1 Blood Sugar Control Goal

### GOAL DESCRIPTION

### TARGET DATE

### MEASURABLE OUTCOME

## 2 Nutrition / Lifestyle Goal

### GOAL DESCRIPTION

### TARGET DATE

### MEASURABLE OUTCOME

## Diabetes Care Interventions

INTERVENTION	FREQUENCY	TIME	INSTRUCTIONS
Blood Glucose Monitoring			
Medication Reminders			
Meal Preparation			
Foot Inspection			
Exercise Support			
Symptom Monitoring			

### Hypoglycemia (Low Blood Sugar) Protocol

**Signs:** Shakiness, sweating, confusion, dizziness, hunger, irritability

**Action:**

### Hyperglycemia (High Blood Sugar) Protocol

**Signs:** Increased thirst, frequent urination, fatigue, blurred vision

**Action:**

### Blood Glucose Log Template

DATE	BEFORE BREAKFAST	AFTER BREAKFAST	BEFORE LUNCH	AFTER LUNCH	BEFORE DINNER	AFTER DINNER	BEDTIME

**DIETARY RESTRICTIONS / MEAL PLAN NOTES**

### Care Plan Review

<b>PLAN START DATE</b>	<b>NEXT REVIEW DATE</b>	<b>REVIEW FREQUENCY</b>
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Client / Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Care Coordinator Signature

\_\_\_\_\_  
Date

## Client Information

CLIENT NAME

DATE OF BIRTH

ADDRESS

PRIMARY PHYSICIAN

PHONE NUMBER

### Emergency Contact

CONTACT NAME

RELATIONSHIP

PHONE NUMBER

## Fall Risk Assessment

### FALL HISTORY

No falls in past year

1 fall in past year

2+ falls in past year

Fall with injury

### FALL RISK FACTORS PRESENT

Gait/Balance Problems

Muscle Weakness

Vision Impairment

Hearing Impairment

Cognitive Impairment

Incontinence/Urgency

Medications (4+ or sedatives)

Orthostatic Hypotension

Foot Problems

Environmental Hazards

### OVERALL FALL RISK LEVEL

Low Risk

Moderate Risk

High Risk

### MOBILITY AIDS USED

None

Cane

Walker

Wheelchair

Grab Bars

Shower Chair

## Home Safety Assessment

AREA	HAZARD IDENTIFIED	RECOMMENDATION	COMPLETED
Entrance/Walkways			
Living Room			
Kitchen			
Bedroom			

Bathroom

Stairs

Lighting

Flooring

## Fall Prevention Goals

### 1 Safety Goal

#### GOAL DESCRIPTION

#### TARGET DATE

#### MEASURABLE OUTCOME

### 2 Mobility/Strength Goal

#### GOAL DESCRIPTION

#### TARGET DATE

#### MEASURABLE OUTCOME

## Fall Prevention Interventions

INTERVENTION	FREQUENCY	INSTRUCTIONS
Supervision during ambulation		
Assist with transfers		
Ensure mobility aid use		
Night light maintenance		
Clear pathways		
Non-slip footwear		
Exercise program support		

### Post-Fall Protocol

**If client falls:**

1. Stay calm. Do not move client if injury suspected.
2. Check for injuries (pain, swelling, inability to move)
3. Call 911 if: head injury, severe pain, cannot get up, loss of consciousness
4. If no serious injury, assist to safe position using proper technique
5. Document fall: time, location, circumstances, injuries
6. Notify supervisor and family immediately

### Care Plan Review

---

PLAN START DATE

NEXT REVIEW DATE

REVIEW FREQUENCY

---

Client / Representative Signature

---

Date

---

Care Coordinator Signature

---

Date

## Client Information

CLIENT NAME

DATE OF BIRTH

ADDRESS

HEIGHT

WEIGHT

WEIGHT BEARING STATUS

### Emergency Contact

CONTACT NAME

RELATIONSHIP

PHONE NUMBER

## Mobility Assessment

PRIMARY REASON FOR MOBILITY LIMITATIONS

WEIGHT BEARING STATUS

Full Weight Bearing (FWB)

Partial Weight Bearing (PWB)

Non-Weight Bearing (NWB)

Weight Bearing as Tolerated (WBAT)

CURRENT MOBILITY LEVEL

Ambulatory/Independent

Ambulatory with Device

Requires Standby Assist

Requires 1-Person Assist

Requires 2-Person Assist

Requires Mechanical Lift

Bed-Bound

EQUIPMENT USED

Standard Cane

Quad Cane

Standard Walker

Rolling Walker

Manual Wheelchair

Power Wheelchair

Hoyer Lift

Sit-to-Stand Lift

Gait Belt

Transfer Board

## Transfer Assessment

TRANSFER TYPE	ASSISTANCE LEVEL	EQUIPMENT NEEDED	SPECIAL INSTRUCTIONS
Bed to Chair			
Chair to Bed			

Bed to Wheelchair

Chair to Standing

Toilet Transfer

Shower/Tub Transfer

Car Transfer

## Mobility / Transfer Goals

### 1 Mobility Goal

#### GOAL DESCRIPTION

#### TARGET DATE

#### MEASURABLE OUTCOME

### 2 Independence Goal

#### GOAL DESCRIPTION

#### TARGET DATE

#### MEASURABLE OUTCOME

## Transfer Technique Instructions

### Safe Transfer Principles

1. Always use gait belt unless contraindicated
2. Lock wheelchair brakes before transfer
3. Position wheelchair at 45-degree angle when possible
4. Use proper body mechanics - bend at knees, not waist
5. Communicate each step with client before movement

**SPECIFIC TRANSFER INSTRUCTIONS FOR THIS CLIENT**

**POSITIONING PREFERENCES / PRECAUTIONS**

**Mobility Care Interventions**

INTERVENTION	FREQUENCY	INSTRUCTIONS
Assist with ambulation		
Transfer assistance		
Range of motion exercises		
Repositioning in bed		
Wheelchair positioning		
Equipment maintenance check		
Skin assessment		

**Weekly Mobility Schedule**

TIME	MON	TUE	WED	THU	FRI	SAT	SUN
Morning Transfer							
Exercise/PT							
Repositioning							
Ambulation							
Evening Transfer							

**Care Plan Review**

**PLAN START DATE**  **NEXT REVIEW DATE**  **REVIEW FREQUENCY**

**PT/OT RECOMMENDATIONS**

[Empty rectangular box for stamp or signature]

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Client / Representative Signature

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Date

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Care Coordinator Signature

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Date