

Lone Star Solutions Weekly Caregiver Documentation Form

Individual: _____

Week of _____ - _____ 2009

Address: _____

Staff Signature _____ ,FCC

Medical Information

Pending medical appointments: _____

Medical Updates: Yes No Date: _____ Hospitalizations: _____

Medication changes: Yes No Please note the change: _____

Has the Nurse been notified of this change: Yes No Date: _____

Waiver Services Summary (Describe the changes or updates to the services listed below)

Case Management: _____

Residential: _____

Nursing: _____

Day Hab/ School: _____

Therapies: _____

Dental: _____

Adaptive Aids: _____

Other Services: _____

Activities

What activity did the individual participate in this week?

How did the individual respond to the activity that they participated in?

What is coming up next week? _____

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Individual: _____ Week of _____ - _____ 2009

Objectives Summary

Objective 1: _____

Describe the specific activity you used to work on the objective listed in the service plan above:

Describe how the individual reacted to the activity (discuss any progress, achievements, problems, concerns, etc):

Has the individual mastered his/her objective? Yes No

Objective 2: _____

Describe the specific activity you used to work on the objective listed in the service plan above:

Describe how the individual reacted to the activity (discuss any progress, achievements, problems, concerns, etc):

Has the individual mastered his/her objective? Yes No

Agency Reports

Contacted (Circle)

Incident Reports? Yes No Date _____

CM/ Nurse/ Hotline

Med Incidents? Yes No Date _____

CM/ Nurse / Hotline

Restraints? Yes No Date _____

CM/ Nurse / Hotline

Have you called the Case Manager/Nurse/Abuse Hotline within 24 hrs? Yes No

Would you like to request an IDT Team Staffing to discuss concerns? Yes No

Caregiver Signature

**FCC
Title**

Date