

PLAN OF CARE KARDEX

Month/Year _____

HEARING	TRANSFER	DAY	INITIALS		
			Days	Evenings	Nights
<input type="checkbox"/> Adequate <input type="checkbox"/> Hard of hearing <input type="checkbox"/> Wears hearing aids <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Face resident when speaking	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Mechanical lift	1			
<input type="checkbox"/> English <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Writing messages <input type="checkbox"/> Utilizes sign language <input type="checkbox"/> Braille <input type="checkbox"/> Signs/gestures/sounds <input type="checkbox"/> Communication board <input type="checkbox"/> No communication skills	<input type="checkbox"/> Brush teeth <input type="checkbox"/> Comb hair <input type="checkbox"/> Perineum care <input type="checkbox"/> Shaving <input type="checkbox"/> Make-up application <input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2	2			
<input type="checkbox"/> Code status <input type="checkbox"/> Allergies	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Day clothes <input type="checkbox"/> Pajamas/sleepwear <input type="checkbox"/> Adaptive equipment	3			
<input type="checkbox"/> Adequate <input type="checkbox"/> Impaired <input type="checkbox"/> Wears glasses <input type="checkbox"/> Wears contacts <input type="checkbox"/> Blind	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Day clothes <input type="checkbox"/> Pajamas/sleepwear <input type="checkbox"/> Adaptive equipment	4			
<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Wheeled walker <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Adaptive equipment <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Independent <input type="checkbox"/> Supervision (cueing) <input type="checkbox"/> Set up <input type="checkbox"/> Restorative feeding <input type="checkbox"/> Dependent on staff <input type="checkbox"/> Feed tube Location of dining: <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner	5			
<input type="checkbox"/> A.M. Days: <input type="checkbox"/> P.M. <input type="checkbox"/> Mon. <input type="checkbox"/> Shower <input type="checkbox"/> Tues. <input type="checkbox"/> Bathtub <input type="checkbox"/> Wed. <input type="checkbox"/> Whirlpool <input type="checkbox"/> Thurs. <input type="checkbox"/> Bed Bath <input type="checkbox"/> Fri. <input type="checkbox"/> Independent <input type="checkbox"/> Sat. <input type="checkbox"/> Supervision <input type="checkbox"/> Sun <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2	<input type="checkbox"/> Continent of Bladder <input type="checkbox"/> Continent of Bowel <input type="checkbox"/> Uses bathroom <input type="checkbox"/> Uses bedside toilet <input type="checkbox"/> Uses bedpan/urinal <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Wears incontinent briefs <input type="checkbox"/> Scheduled toilet plan (specify) _____ _____ <input type="checkbox"/> Incontinent check and change q _____ <input type="checkbox"/> Ostomy care <input type="checkbox"/> Adaptive equipment	6			
<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	<input type="checkbox"/> Continent of Bladder <input type="checkbox"/> Continent of Bowel <input type="checkbox"/> Uses bathroom <input type="checkbox"/> Uses bedside toilet <input type="checkbox"/> Uses bedpan/urinal <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Wears incontinent briefs <input type="checkbox"/> Scheduled toilet plan (specify) _____ _____ <input type="checkbox"/> Incontinent check and change q _____ <input type="checkbox"/> Ostomy care <input type="checkbox"/> Adaptive equipment	7			
Specify: _____ _____ _____ _____ _____	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	8			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	9			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	10			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	11			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	12			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	13			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	14			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	15			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	16			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	17			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	18			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	19			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	20			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	21			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	22			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	23			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	24			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	25			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	26			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	27			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	28			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	29			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	30			
	<input type="checkbox"/> Independent <input type="checkbox"/> Assist of 1 <input type="checkbox"/> Assist of 2 <input type="checkbox"/> Turn q _____ <input type="checkbox"/> Trapeze bar <input type="checkbox"/> Adaptive equipment	31			

Transcribed by: _____

NAME-Last	First	Middle	Attending Physician	Record No.	Room/Bed
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PLAN OF CARE KARDEX

Month/Year _____

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
DIET: % Consumed 4 = 100% 3 = 75% 2 = 50% 1 = 25%	Break																															
	Snack																															
	Lunch																															
	Snack																															
	Dinner																															
	Snack																															

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
BLADDER ACTION: C = Continent I = Incontinent	Day																															
	After																															
	Night																															

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
BOWEL ACTION: C = Continent I = Incontinent S = Small M = Medium L = Large D = Diarrhea	Day																															
	S/M/L/D																															
	After																															
	S/M/L/D																															
	Night																															
	S/M/L/D																															

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
BATH: S = Shower B = Bed T = Tub	Nights																															
	Days																															
	Evenings																															

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
INTAKE (mL)	Nights																															
	Days																															
	Evenings																															

OUTPUT (mL)	Nights																															
	Days																															
	Evenings																															

Initials	Signature	Initials	Signature

NAME-Last	First	Middle	Attending Physician	Record No.	Room/Bed
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