Care Plus
Professionals, Inc.
Enriching Life Through Committed, Compassionate Care

23110 State Road 54 Lutz, Fl 33549
Phone no : 813.519. 7306
Email Address: careplusprofessionalsinc@gmail.com

Permission to Provide Care in the Home

I give my permission for Care Plus Professionals, Inc to provide care in my home.

I am aware that an RN will be coming to setup an appointment to do a full evaluation and medical assessment as required by the state of Florida.

I understand this assessment will be done within a 24–48-hour period & is necessary in order to receive care in my home, without which care cannot be provided.

_____ _____

Print Name of Client Date

_____ _____

Signature of Client Date

___ Client; ___ POA; ___ Spouse

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☐ Original Plan
☐ Amended Plan

Medical Plan of Treatment

Date: _____

NAME: DOB:

DIAGNOSES AND CONCURRENT CONDITIONS:

MEDICATIONS: (see attached)

Is the patient Homebound:_____
Limitations and Reason:_____

What level of assistance is required w/ medications?

LIMITATION (CIRCLE)

			COMMENTS:
FREQUENT FALLS	PARALYSIS	SPEECH	
VISUAL IMPAIRMENT	ENDURANCE	ASSISTIVE DEVICES	
DISORIENTED	PAIN	BALANCE	
DECUBITIS	OXYGEN	INCONTINENCE	

COGNITIVE IMPAIRMENT (CIRCLE)

				COMMENTS:
ORIENTED	CONFUSED	DEPRESSED	LETHARGIC	
DISORIENTED	FORGETFUL	AGITATED	COMBATIVE	

IMPAIRMENTS IN ACTIVITIES OF DAILY LIVING: PLEASE INDICATE THE LEVEL OF ASSISSTANCE NEEDED:

I = INDEPENDENT
S = SUPERVIOSION/STAND BY ASSIST
A = HANDS ON ASSISTANCE
T = TOTAL HELP

		COMMENTS:
BATHING	_____	
CONTINENCE CARE	_____	
EATING	_____	
TOILETING	_____	
TRANSFERING	_____	
DRESSING	_____	

PLEASE DETAIL YOUR PLAN OF CARE FOR THE PATIENT, SPECIFY THE CAREGIVER'S LEVEL OF CARE YOU ARE CURRENTLY ORDERING. PLEASE INDICATE FREQUENCY AND DURATION OF CARE.

_____ HOURS PER DAY _____ DAYS PER WEEK _____ # OF WEEKS

PHYSICIAN'S NAME: PHYSICIAN'S SIGNATURE: DATE: