

MONTHLY CARE SUMMARY

Please check appropriate box: Family Caregiver Independent Caregiver

(Must be submitted at the end of each month with timesheets.)

General Information:

Month: _____ Year: _____
Claimant's name: _____
Caregiver name: _____ Relation: _____
Physician's name: _____ Phone: _____

List medications and times given:

(Only list each medication once and the time(s) of day normally given. This is not a daily list, just a general description of medications and times given.)

1 _____	5 _____	9 _____
2 _____	6 _____	10 _____
3 _____	7 _____	11 _____
4 _____	8 _____	12 _____

Personal care given (circle method or fill in the blank):

Bathing: In bed In tub In shower
Feeding: By mouth By tube Pediasure (or other) # cans/day _____
Type of brand _____
Toileting: Passed urine Has catheter in place
Mouth/teeth care: Yes No
Turning: Every _____ hours
Exercise arms and legs every day: Yes No

Status:

Bowel movement: Yes No
Skin condition: Good, or red areas-location: _____
Sore, open areas-location: _____

List equipment being used:

1 _____	4 _____
2 _____	5 _____
3 _____	6 _____

If you need more space for any category above, please attach a second page.

Any comments for Nurse Case Manager? _____

Caregiver Signature: _____ Date: _____