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**: _____