SPERO - Home health care

Date D D M M Y Y HHC No

PATIENT DETAILS

Name: First Name Middle Name Surname

Address: Door/House No Street

Locality Tehshil District

City: Pin Code:

/

Identification Mark: 1. 2.

Next in Kin/Spouse Name:

/

ALLERGIES

Notes:

VACCINATIONS

Notes:

SOCIAL HABITS

Tobacco: Y ☐ N ☐ Alcohol: Y ☐ N ☐

Notes:

PERSONAL INFORMATION

DOB: D/D M/M Y/Y Age:

Blood Group: Rh:

Height: Weight:

Sex: Marital Status:

Family Doctor:

/

Clinic/Hospital:

Insurance:

Other:

PAST MEDICAL HISTORY

Diabetes	
Hypertension	
Coronary Artery Disease	
Stroke	
Epilepsy	
COPD/Asthma	
Behavioral Illness	
Surgery in Past	
Other:	

HHC No

RECENT HOSPITALIZATION DETAILS

Diagnosis/Medical Condition: _____

Hospital Name: _____

Admitted at: Bed No _____ Ward _____ Floor _____

Primary Consultant Name: _____

/ _____ _____

Other Consultant: _____

/ _____ _____

Duration of Hospitalization: D/D M/M Y/Y To D/D M/M Y/Y Days: _____

CURRENT TREATMENT PLAN

Tablet: _____

_____

Injections: _____

_____

IV Fluids: _____

_____

Interventions: _____

_____

Notes: _____

_____

_____

FOLLOW-UP INSTRUCTIONS

Physical: _____

_____

Investigations: _____

_____

Interventions: _____

_____

Assistance: _____

_____

Referred By: _____

/ _____

_____

Home Healthcare Service Reference for:

HCA		Physiotherapist	
Nurse		Lab/Investigation	
Physician Assistant		Equipments	
Other:			

ASSESSMENT BY HCM

HHC No ☐

Assessment Place: _____ HCM Name: _____

BASELINE:

A ☐ V ☐ P ☐ U ☐

Airway: Open ☐ Closed ☐

Breathing: Present ☐ Compromised ☐ Absent ☐

Circulation: Radial ☐ Present ☐ Absent ☐

Temp (Core) .....*F

Pulse: ..... /min

RR: ...../min

BP: ...../mmHg

BSL: ..... mg/dl

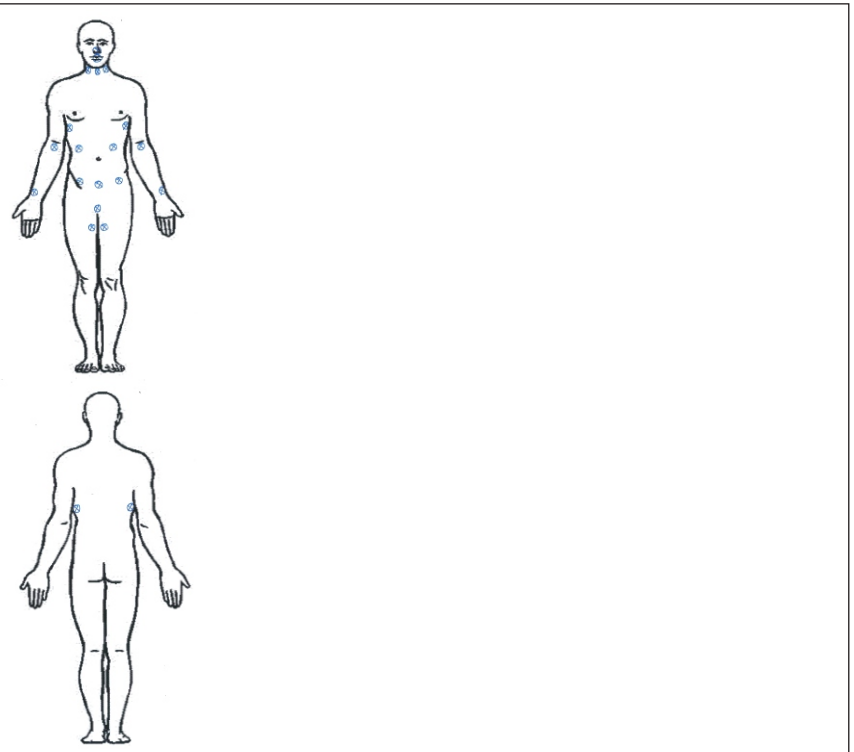
SpO_2: ..... %

GCS Total: ...../15

Skin Perfusion: Normal ☐ Abnormal ☐

PHYSICAL ASSESSMENT:

	Abnormality	If Yes, Comment
HEENT	Y ☐ N ☐	
Neck	Y ☐ N ☐	
Chest	Y ☐ N ☐	
Abdomen	Y ☐ N ☐	
Pelvis	Y ☐ N ☐	
Back	Y ☐ N ☐	
Upper Limb	Y ☐ N ☐	
Lower Limb	Y ☐ N ☐	
General	Y ☐ N ☐	



Clinical Impression of HCM: _____

RECOMMENDATIONS

HHC No

HCA Services:	
For 4 Hrs	
For 8 Hrs	
For 12 Hrs	
For 24 Hrs	
Nurse Services:	
For 4 Hrs	
For 8 Hrs	
For 12 Hrs	
For 24 Hrs	
Bed Sore Care	
Companion	
Enema	
Monitoring Vital Signs	
Monitoring Drains	
Manage Medication Schedule	
Nurse Visit with ECG Machine	
Port Care	
Patient & Family Education	
Positioning	
Ryles Tube Feeding	
Spong Bath	
Training Insulin injection	
Wound Care (Dressing)	

Physician Assistant Services:	
Routine General check-up & Physical examinations (Preventive Check-up)	
Traditional home visits (Common Ailments)	
On-going treatment of medical conditions	
Physician review/consultation for authorization of medical care, nursing care, pharmacy, diagnostics and referral to physical therapy and specialized rehabilitation services	
Post-Surgical care:	
Ambulation	
BSL on Glucometer	
Bladder Wash	
Bladder Wash (In Situ Cathetor)	
Bilateral Stitch Removal	
Catheter removal/insertion/care	
Colostomy Care	
Counselling	
Central line (Advance IV)care and removal	
Cast - monitoring and removal	
Condom Cathetor	
Dressing: Small	
Dressing: Medium	
Dressing: Large	
Doctor Visit with Glucometer	
Doctor Visit with ECG Machine	
Glove Drain Catherization	
ICD care and assessment	
Insulin injectable	

ICD Dressing	
IV infusion care and therapy	
Injections (IV, IM, SC)	
Manual Evacuation of Feaces	
Nebulization therapy	
Need based Medical Transportation	
Ongoing-Preventive Care	
Oxygenation therapy	
Oxygen therapy	
Positioning advice	
PEG care	
Pain management	
Routine ECG monitoring	
RT removal/insertion/care	
Routine diet management	
Stoma care	
Sore care advice	
Suture/Stapler removal	
Tracheobronchial Suctioning	
Traction	
Tube feedings	
Tracheostomy removal & replacement	
Unilateral TKR Stitch Removal	
V-P Shunt care	
Vitals monitoring (Pulse, BP, SPO2, RR etc)	
Ventilator support (C-PAP/Bi-PAP)	
Wound care management & Skin care	

Physiotherapy Services:			
Ankle and foot:		Joint mobilization	
Footwear correction		Nervous tissue mobilization	
Gait and posture training		Orthotic prescription	
Range of motion		Posture retraining	
Strengthening		Range of motion	
Taping		Stretching	
Cervical Spine/ Shoulder		**Wrist and Hand:**	
Core strengthening		Hand strengthening	
Joint Mobilisations		Joint mobilizations	
Neural tissue mobilisations		Range of motion	
Progressive resisted training		Taping	
Posture retraining		**Others:**	
Stretching		Dementia physiotherapy rehab	
Taping		Gait Apraxia	
Elbow:		Muscular dystrophy rehab	
Joint Mobilisations		Multiple Sclerosis Rehab	
Range of motion exercises		Nerve injuries rehab	
Progressive resisted training		Orthotic prescription	
Stretching		Parkinson's Rehabilitation	
Taping		Post Head Injury Rehabilitation Coma stimulation	
Hip/Knee:			
Gait training		Paraplegic rehabilitation	
Orthotic prescription		Post Spine Surgery Rehab	
Post Surgery muscle training		Postural Retraining	
Range of motion		Stroke Rehabilitation	
Strength training		Vestibular Rehabilitation: Positional vertigo, Hypofunction rehabilitation	
Taping			
Lumbar Spine/SI joint:			
Core strengthening			

VALUE ADDED SERVICES:

☐ Lab/Investigations: _____ ☐ Equipment: _____ ☐ Pharmacy: _____ ☐ Other: _____

_____ _____ _____ _____

_____ _____ _____ _____

HHC No

CALL THE CONSULTANT

Name: _____ Y☐ N☐ NA☐

Advice: _____

_____

_____

Name: _____ Y☐ N☐ NA☐

Advice: _____

_____

_____

Billing Estimate:

CONSENT FROM NEXT IN KIN/SPOUSE

I, Mr/Mrs/Ms _____ hereby accept the treatment recommended by SPERO's HCM after due consultation with Dr. _____

All the likely consequences of the treatment are explained to me in language, I best understand & would be surely borne by me, at my risk under all circumstance

Date:

Place:

Name: Counter Signature by HCM

(Signature) (Signature)

Terms & Conditions

Name of Patient: First Name Middle Name Surname HHC No

Address: Door/House No Street Locality Tehshil District

City: Pin Code: /

Professional	Professional Name	Recommended Service	Day/s	Frequency	Timing	Reporting Instruction
HCA						
Nurse						
Physician Assistant						
Physiotherapist						

REMINDER MANAGEMENT:

Services	Date	Time	Responsible Person	Mode of Reminder	Comment
Physical Follow Up					
Lab/Investigation Follow Up					
Intervention Follow Up					
Assistance					
Drugs/ Consumables/Equipments					
Other:					