Patient Personal Care Needs Evaluation

Date: _____

Patient Name: _____

Patient ID: _____

Evaluation Details

This evaluation aims to identify the personal care needs of the patient to provide optimal support and care.

1. Mobility

Does the patient require assistance with mobility? Yes / No

If yes, specify the type of assistance needed: _____

2. Hygiene

Can the patient perform daily hygiene tasks independently? Yes / No

If no, specify the tasks needing assistance: _____

3. Nutrition

Does the patient require assistance with meal preparation or feeding? Yes / No

If yes, please elaborate: _____

4. Medication Management

Is the patient able to manage their own medications? Yes / No

If no, specify the assistance required: _____

5. Emotional Support

Does the patient show signs of needing emotional support? Yes / No

If yes, please elaborate: _____

Recommendations

Based on the evaluation, the following recommendations are made: _____

Evaluator Name: _____

Evaluator Signature: _____