[redacted]

Sunrise - Lakeside Adult Day Health Care Centers

Comprehensive Person Centered Plan

❒ Sunrise
❒ Lakeside

Registrant: _____ Med. Rec. # _____

Name by which registrant prefers to be addressed: _____

Long Term Goals /Valued Outcome/Prognosis (✓):

Date	Registrant would like to …	E.D.A. *		
		Date	Ongoing	Resolved
	❒ Maintain his/her current functional status			
	❒ Maintain his/her current health status			
	❒ Improve his/her level of health status			
	❒ Improve functioning status to his/her optimum level			
	❒ Improve understanding of his/her health condition(s)			
	❒ Have health care needs met			
	❒ Have personal care needs met			
	❒ Avoid or delay institutionalization			
	❒ Be able to remain in the community			
	❒ Receive services which provide support and respite for his/her family and/or caregivers			
	❒ Other			

Circle of Support – Related Issues:	Date:_____		Date:_____		Date:_____		Date:_____		Date:_____	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Registrant/Desig. Rep. Invited to participate in ICCP Meeting.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Registrant/Desig. Rep. Attended and approved Plan	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Registrant is a Candidate for Medication Self-Administration	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	▪ Already self medicating If "**NO**" to Self-Med., rationale:_____		▪ Already self medicating If "**NO**" to Self-Med., rationale:_____		▪ Already self medicating If "**NO**" to Self-Med., rationale:_____		▪ Already self medicating If "**NO**" to Self-Med., rationale:_____		▪ Already self medicating If "**NO**" to Self-Med., rationale:_____	

* **E.D.A.** = Estimated date of Achievement (of Goal)

[redacted]

Discharge Plan:

	Date:	Date:	Date:	Date:	Date:
Is placement in ADHC appropriate at this time?	**Yes** ☐ • w/com. svcs: _____ **No** ☒	**Yes** ☐ • w/com. svcs: _____ **No** ☒	**Yes** ☐ • w/com. svcs: _____ **No** ☒	**Yes** ☐ • w/com. svcs: _____ **No** ☒	**Yes** ☐ • w/com. svcs: _____ **No** ☒
If "**NO**" to above, indicate Registrant choice(s):	• LTHHC • SNF • Adult Home • Assist. Living • Other:_____	• LTHHC • SNF • Adult Home • Assist. Living • Other:_____	• LTHHC • SNF • Adult Home • Assist. Living • Other:_____	• LTHHC • SNF • Adult Home • Assist. Living • Other:_____	• LTHHC • SNF • Adult Home • Assist. Living • Other:_____
Potential for remaining in community:	☒ Good ☐ Fair ☐ Poor ☐ N/A Active D/C Plan is in progress: • Yes • No • Pt teaching is part of D/C plan:_____	☒ Good ☐ Fair ☐ Poor ☐ N/A Active D/C Plan is in progress: • Yes • No • Pt teaching is part of D/C plan:_____	☒ Good ☐ Fair ☐ Poor ☐ N/A Active D/C Plan is in progress: • Yes • No • Pt teaching is part of D/C plan:_____	☐ Good ☐ Fair ☐ Poor ☐ N/A Active D/C Plan is in progress: • Yes • No • Pt teaching is part of D/C plan:_____	☒ Good ☐ Fair ☐ Poor ☐ N/A Active D/C Plan is in progress: • Yes • No • Pt teaching is part of D/C plan:_____
	Indicate Disc. providing education (by Symbol (s))	Indicate Disc. providing education (by Symbol (s))	Indicate Disc. providing education (by Symbol (s))	Indicate Disc. providing education (by Symbol (s))	Indicate Disc. providing education (by Symbol (s))
Primary Nurse:					

☒ = Actual or Potential Care Planning Item

Team/Circle of Support Signatures/Meeting:

Note: Use **"R"** as the symbol for indicating registrant's signature and **"F"** for family or, designated representative's signature.

N - Nursing
S - Social Work
D – Dietary
P – Phys. Therapy
O – Occ. Therapy
A/R –Activ./Rec.

*Disc. Symbol	Signature/Title	*Disc. Symbol	Signature/Title	*Disc. Symbol	Signature/Title	*Disc. Symbol	Signature/Title	*Disc. Symbol	Signature/Title
MD Signature of review/Date		MD Signature of review/Date		MD Signature of review/Date		MD Signature of review/Date		MD Signature of review/Date	