Missouri Council for In-Home Services

"Working Together To Advance Home Care."

Call Documentation

Name of Client:	Date/Time of Conversation:	Caller's Name:

1. Client has adequate food and water supply.	YES	NO	
2. Client has adequate medication supply.	YES	NO	
3. Client has adequate heating/cooling system.	YES	NO	
4. Client feels comfortable in current living environment.	YES	NO	
5. Client understands when to call 911.	YES	NO	
6. Client has our office number to call as needed.	YES	NO	
7. Client is keeping physician appointments as scheduled.	YES	NO	
8. Client has a good support system.	YES	NO	
9. Client services/care plan is adequate.	YES	NO	
10. Client aide is attending to the client per the care plan.	YES	NO	
11. Client understands the COVID-19 hotline number.	YES	NO	877-435-8411
12. Is client running any fever?	YES	NO	
13. Does client have any complaints of respiratory issues	YES	NO	
14. Does client have any complaints of GI Issues?	Yes	NO	

If numbers 1 – 11 are marked **NO**, please explain in the space below and who you contacted for follow-up (supervisor, REV Team, agency nurse, etc.). If numbers 12 – 14 are marked **YES**, please explain in the space below and who you contacted for follow-up (supervisor, REV Team, agency nurse, etc.).

Use the space below to document any concerns not listed above and who you notified for follow-up (supervisor, agency nurse, REV Team, etc.).

PO Box 1803; Jefferson City, MO 65102
O: 573-634-5272
www.mohomecare.org