

Ariel Clinical Services

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Monthly Summary

Name: _____ Month/Year: _____

Home:

Note any areas of concern regarding incidents this month:

FAMILY/FRIENDS: Have you had enough contact with your family by phone and /or visits? Is this enough contact or would you like more?

COACH TIME:

HEALTH (Please mark those that apply and address questions):

Doctor's Appointment(s) Date: _____

Dental Appointment(s) Date: _____

Eye Exam Date: _____

Therapies (Physical Therapy, etc.) Dates: _____

Emergencies? Dates: _____

Accidents/Seizures? Dates: _____

Medication Errors? Dates: _____

Nursing Reviews? Dates: _____

Counseling? Dates: _____

Medication Changes? _____

Are you in the BEST possible health? _____

Weight _____

Last Physical _____

Last Dental _____

Last Vision _____

Comments:

Assisting HHP or Staff: _____

Supervisor: _____ Date: _____