SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE
iCare

DEMOGRAPHIC LABEL

# Patient Care Needs - Essential Caregiver Program

| | |
|---|---|
| Patient Name: | |
| Caregiver Name: | |
| Patient Room: | |

## Patient Care Needs

| | Date | Initials |
|---|---|---|
| Nutritional Assist: | | |
| Bathing Assist: | | |
| Mobility Assist: | | |
| Adaptive Aid Assist: | | |
| Cognitive Support: | | |
| Communication/Language Assist: | | |
| Pre-Transition Home Assist: | | |
| Emotional Support: | | |
| Other Needs as Identified by the Care Team: | | |
| Frequency and Duration of Visits: | | |

| | |
|---|---|
| Caregiver orientation date: | Caregivers Signature:<br>Date signed: |
| Feedback: | Employee Signature:<br>Date signed: |