

# PLAN OF CARE

Patient \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Order \_\_\_\_\_ Equipment \_\_\_\_\_

Manufacturer \_\_\_\_\_ Model \_\_\_\_\_

Category I Equipment \_\_\_\_\_

DATE	SERIAL #	P M	EQUIPMENT/COMMENTS	TECH

## Patient Education Review

Date	Equipment Safety	Cleaning and Disinfection	Physician's Orders	Emergency & Supply Numbers	Tech

## Infection Control

QUESTION	YES	DATE	DESCRIBE
Have you been hospitalized since last visit?			
Have you had any respiratory infections since last visit?			