



ROYAL PALM ADULT DAY CARE CENTER

**CARE PLAN REVIEW / QUARTERLY CARE PLAN REVIEW**

**Participant Information**

Participant Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Start of Care (SOC) Date: \_\_\_\_\_

\_\_\_\_\_

**Review Information**

Review Type (check one):

Quarterly Review

Significant Change

Annual Review

Review Date: \_\_\_\_\_

\_\_\_\_\_

**Summary of Participant Status**

Since the last review, the participant's overall status is best described as (check one):

Stable

Improved

Declined

Brief summary of current functioning, participation, and response to services:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Review of Goals**

**Goal #1:** \_\_\_\_\_

Status (check one):  Progressing  Maintained  Modified

Comments: \_\_\_\_\_

**Goal #2:** \_\_\_\_\_

Status (check one):  Progressing  Maintained  Modified

Comments: \_\_\_\_\_

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**Services Review**

Current services continue to meet the participant's needs?

Yes  No

If no, describe recommended changes:

\_\_\_\_\_

\_\_\_\_\_

**Safety Considerations Update**

Any changes to safety needs or precautions?

No changes

Changes noted below:

\_\_\_\_\_

\_\_\_\_\_

**Care Plan Update**

Based on this review, the care plan will be:

Continued without changes

Updated / Revised

Effective Date of Changes (if applicable): \_\_\_\_\_

\_\_\_\_\_

**Participant / Representative Involvement**

The participant and/or legal representative was offered the opportunity to participate in this care plan review.

- Participated
  - Declined
  - Not available
- 

**Signatures**

Facility Representative Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Participant / Legal Representative Signature (if applicable): \_\_\_\_\_

Date: \_\_\_\_\_