

SERVICE PLAN & CONTACT RECORD

Patient Name: _____ Pt. Phone Number: _____ Date of MD Order: _____
 Patient Address: _____ SSN: _____ - _____ - _____ Rep# _____
 Start of Therapy Date: _____ Visit Date: _____ Hosp. D/C Date: _____ Initial Set Up Home Follow Up
 Emergency Contact: _____ EC Phone: _____ EC Relationship to Pt. _____
 Diagnosis / Surgery: _____

ORDER / PRESCRIPTION

Physician's Name: _____ Physician's Phone: _____ Contact: _____
 Device: _____ Hours / Day: _____ Duration of Therapy: _____
 Settings: _____ Advancement of Settings: _____
 Settings Limits: _____ Long Term Goal: *Enhance rehabilitation and increase range of motion.*
 Other: _____

SERVICE GOALS	NEEDS / PROBLEMS <small>Check only needs/problems that apply. Add any other needs/ problems identified.</small>	ACTIONS <small>Check all that apply. Add any other actions required.</small>
A. JACE Systems coordinates services with other organizations when indicated	<input type="checkbox"/> Other organization(s) provides care/service to patient. <u>Company</u> _____ <u>Phone Number</u> _____ _____ _____	<input type="checkbox"/> Informed other organization(s) of service coordination needs <input type="checkbox"/> Other: _____
B. Patient/Caregiver is able to describe/demonstrate knowledge of environmental safety factors for CPM use	<input type="checkbox"/> Unclean Environment <input type="checkbox"/> No Telephone Accessible <input type="checkbox"/> Other: _____ <input type="checkbox"/> No Smoke Alarm Present <input type="checkbox"/> Inadequate Space/Location for CPM Use <input type="checkbox"/> Ungrounded Electrical Outlet(s)	<input type="checkbox"/> Informed Patient/Caregiver of safety risks <input type="checkbox"/> Installed 3-Prong adapter <input type="checkbox"/> Advised to have electrician check circuit <input type="checkbox"/> Notified physician <input type="checkbox"/> Other: _____
C. Patient/Caregiver is able to demonstrate adaptation to functional limitation for CPM use	<input type="checkbox"/> Blind/Vision Deficit <input type="checkbox"/> Deaf/Hearing Deficit <input type="checkbox"/> Aphasic/Speech Deficit <input type="checkbox"/> Chair or Bed Bound <input type="checkbox"/> Non-English Speaking <input type="checkbox"/> Patient requires assistance to operate CPM <input type="checkbox"/> Caregiver is unable to provide assistance <input type="checkbox"/> Caregiver is unavailable for assistance <input type="checkbox"/> Illiterate/Unable to read	<input type="checkbox"/> Notified physician <input type="checkbox"/> Informed other organization providing service to patient of coordination of care issue(s): _____ <input type="checkbox"/> Other: _____
D. Patient/Caregiver is able to describe/demonstrate: • safe equipment operation • passive range of motion to affected joint as tolerated • specific range goal • to advance settings only as tolerated	<input type="checkbox"/> Use of Knobs <input type="checkbox"/> Correct Settings <input type="checkbox"/> Emergency Stop <input type="checkbox"/> Proper CPM position <input type="checkbox"/> Other: _____ <input type="checkbox"/> Use of Lock/Brakes <input type="checkbox"/> Getting in and out of CPM device <input type="checkbox"/> Use/application of softgoods/disposables <input type="checkbox"/> Patient does not tolerate therapy	<input type="checkbox"/> Notified physician <input type="checkbox"/> Scheduled additional home teaching session <input type="checkbox"/> Scheduled phone follow up <input type="checkbox"/> Other: _____
E. Patient/Caregiver is able to describe how to maintain CPM device. • clean device with soft cloth	<input type="checkbox"/> Functional limitations (as described above) impede equipment maintenance <input type="checkbox"/> Caregiver unavailable or unable to assist with equipment maintenance <input type="checkbox"/> Other: _____	<input type="checkbox"/> Notified other organization of service needs <input type="checkbox"/> Other: _____
F. Patient/Caregiver is able to describe when to: • discontinue CPM use • contact physician • contact JACE Systems at 800-800-4276 • return CPM device	<input type="checkbox"/> Anticipated duration of therapy differs from physician's order <input type="checkbox"/> Patient/Caregiver does not have physician's phone number <input type="checkbox"/> No Telephone Accessible <input type="checkbox"/> Other: _____	<input type="checkbox"/> Provided Patient/Caregiver phone number(s) for service calls or equipment questions during: • Normal business hours • Weekends, evenings & holidays <input type="checkbox"/> Provided Patient/Caregiver with physician's phone number for medical questions <input type="checkbox"/> Notified physician

TEACHING SUMMARY

Verbal Written Instructions Device Operation Manual Provided to: Patient Caregiver
Reviewed: Patient Rights & Responsibilities Patient Complaint/Grievance Process How to contact JACE Systems (800-800-4276)

PROGRESS NOTE

JACE REPRESENTATIVE SIGNATURE	DATE	PATIENT/CAREGIVER SIGNATURE	DATE
_____	_____	_____	_____