LIGHTHOUSE PROGRAM
6-Month Call Sheet

Service Recipient's Name: _____ **Date:** _____

Does the service recipient have dementia or cognitive deficits? If so, check the box(es) to the right.

☐ Dementia
☐ Cognitive deficits

Who did you speak with?

_____

Are there any issues or concerns related to the care? If so, what?

_____

_____

_____

Are there new medications?

_____

_____

_____

Are there new diagnoses?

_____

_____

_____

Are there new mobility issues?

_____

_____

_____

Are there changes to the POC?

_____

_____

_____

Comments

_____

_____

_____

_____ _____

Agency designee (if making 6-month call) **Date**

_____ _____

RN Signature **Date**