

ATTENTION	

RE: PERSONAL ASSISTANCE GUIDELINES FOR: **DELEGATED PHYSIOTHERAPY TASKS**

Was the 'Decision to Delegate' tool used to determine if it is safe and suitable to delegate this task? □ Yes □ No □ Review PARIS ID: _____ Client: _____ Phone #: ____ Physician: ____ Phone #: ____ Client is able to direct own care?

□ Yes □ No Family or Client's Key Caregiver: _______Relationship to Client: ______ Phone #: _____ This is to confirm home support has agreed to accept the task of **ASSISTING WITH**: □ Stretching / ROM □ Warm / Cold Packs □ Therapeutic Pool □ Exercises □ Assisted Cough □ Prosthetics/Orthotics □ Other: _____ VCH Community staff will continue to monitor the client's condition. They should be contacted as soon as possible by Home Support staff if there are any concerns about the task(s) or a change in client's condition. VCH Community Contact: Name: ______ Phone: _____ Date: _____ **TASK GUIDELINES:** The Unregulated Care Provider is to: 2. 3. 4. Additional Information:

ASK COMPETENCY Persons Trained:	: (Complete if applicable) Name) Date	Competence Demon	strated (Y/N)
Agency Supervisor:				,
Unregulated Care Provider(s):				
	AILED: (X All that apply)			
Written Instructions Diagrams Photographs				
Other				
	can be transferred to anoth 's status it is the responsibil			
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