Family Caregiver Emergency Care Plan

ADRC

Aging & Disability Resource Center

Serving the Counties of Grant, Green, Iowa and Lafayette

1-877-SWI-ADRC

www.adrcswwi.org

Family Caregiver Emergency Care Plan

Care Recipient: _____ **Date of Birth:** _____

Address: _____ **Home Phone Number:** _____

Social Security Number: _____ Senior Care Number: _____

Medicare Number: _____ Medicaid Number: _____

Supplemental Insurance Company: _____ ID Number: _____

Primary Care Physician and Specialist Information

Name of Physician: _____

Clinic (Name and Location): _____

Phone Number: _____

Name of Specialty Doctor: _____

Clinic/Hospital (Name and Location): _____

Phone Number: _____

Receiving Treatment for: _____

Hospital Preference

Hospital Name: _____

Location: _____

Phone Number: _____

Pharmacy Preference

Pharmacy Name: _____

Location: _____

Phone Number: _____

Advanced Directives

Advance Directives Prepared: Yes No

If yes, where are these documents located:

_____

_____

Person(s) listed as Power of Attorney (POA) of Healthcare:

_____ _____

Is the POA of Healthcare Activated? Yes No

Person(s) listed as Power of Attorney (POA) of Finances:

_____ _____

Finances

Name of Banking Institution: _____

Name of Banker: _____

Phone Number: _____

Safe Deposit Box Number: _____

Others listed on box: _____

Location of Key(s): _____

Is the Care Recipient able to handle finances? (Able to pay bills, balance checkbook, and manage his or her own money?)

Yes No

Please explain:

_____

_____

Caregiver Information

Primary Caregiver: _____ Relationship: _____

Home Phone Number: _____ Cell Phone: _____

Work Phone Number: _____

Back-up Caregiver: _____ Relationship: _____

Home Phone Number: _____ Cell Phone: _____

Work Phone Number: _____

Other Caregivers/Family Members:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Emergency Contact Information:

Primary Emergency Contact: _____ Relationship: _____

Home Phone Number: _____ Cell Phone: _____

Work Phone Number: _____

Other Emergency Contacts:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Health History (Please see list of prior doctor appointments at the end of the book)

Primary Diagnosis: _____

Is currently being treated for:

Asthma:	Yes	No	COPD:	Yes	No
Heart Disease:	Yes	No	Cancer:	Yes	No
HBP:	Yes	No	Alzheimer's/Dem.:	Yes	No
Diabetes:	Yes	No	Other: _____		

Does the Care Recipient receive dialysis or other regular treatment series: Yes No

Please explain:

_____

_____

_____

_____

Allergies and Drug Sensitivities:

Item(s) allergic/sensitive to	*Reaction*	*Medications Taken*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Prior Surgeries

Approximate Date	Procedure
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Use of Alcohol (please list frequency & amounts): _____

Use of Tobacco (please list frequency): _____

Medications: Please list all medications that are currently being taken.

Name	Dose/Frequency	Taken for	Doctor Prescribed by	Notes

Assistance Needs:

Please describe the level of support your Care Receiver needs with the tasks listed below. Include frequency of assistance (time of day, day of week, etc.), as well as any information that would benefit someone who is unfamiliar with the task.

Getting in and out of the bath/shower, preparing bath, before and after hygiene prep:
(Include information on person hygiene needs such as shaving, tooth & denture are, hair, etc.)

Dressing and Underdressing:
(Include ability to put on, fasten and remove all clothing, select appropriate attire for weather, etc.)

Completing toileting activities:
(Able to transfer on/off toilet, cleanse self, change pads, perform catheter care, etc.)

(Continued on next page)

Getting in and out of a bed or wheelchair:
(Without any personal assistance or the use of assistive devices)

Using utensils and eating without assistance:
(Ability to prepare food on plate, feed self, drink from cup, etc.)

Prepare own meals:
(Able to plan and prepare meals, handle food safety, cook on stove safely, etc.)

Ambulate:
(Able to ambulate independently without the use of a gait belt, arm support or assistive device)

(Continued on next page)

Medication Management:
(Able to prepare and take medication reliable and safely, including correct dose)

Complete heavy housework and outside chores:
(Ability to perform housekeeping tasks, vacuum, etc.)

Shop for personal items and/or groceries:
(Able to plan, select and purchase items independently)

Travel in a can, taxi, bus or car:
(Ability to drive a car, call for public transportation, etc.)

(Continued on next page)

Answer the phone or place a call:
(Make emergency calls, use adaptive amplification systems, etc.)

_____

_____

_____

_____

_____

Nutritional Health:

Does Care Recipient:

Have any tooth/mouth problems that make it difficult to eat, chew or swallow?
Yes No

Please explain: _____

Have an illness that has changed the kind and/or amount of food they can eat?
Yes No

Please explain: _____

Have three or more drinks of beer, liquor or wine every day?
Yes No

Please explain: _____

Without intention, has care recipient experienced any weight gain or loss within the last six months?
Yes No

Please explain: _____

Does care recipient eat an adequate amount of fruits, vegetables and dairy products?
Yes No

Please explain: _____

(Continued on next page)

Please list any special dietary notes, such as favorite foods, snack preferences, preparation tips, etc.:

Personal Information:

What activities does your loved one enjoy?

Are there situations that your loved one finds uncomfortable, distressing or annoying, if so please explain.

What should the caregiver do if your loved one becomes difficult, upsets or tells the caregiver to leave?

If substitute care is necessary what suggestions do you have to make the transition easier for everyone?

Notes section for emergency care plan:

Notes for emergency care plan:

Typical Daily Routine:
* Please list routines and activities

AM Hours

1:00 AM	
2:00 AM	
3:00 AM	
4:00 AM	
5:00 AM	
6:00 AM	
7:00 AM	
8:00 AM	
9:00 AM	
10:00 AM	
11:00 AM	
12:00 PM	

PM Hours

1:00 PM	
2:00 PM	
3:00 PM	
4:00 PM	
5:00 PM	
6:00 PM	
7:00 PM	
8:00 PM	
9:00 PM	
10:00 PM	
11:00 PM	
12:00 AM	

Medical Appointments:

Date	*Doctor Seen*	*Reason for Appointment*	*Notes/Diagnosis*

Medical Appointments:

Date	*Doctor Seen*	*Reason for Appointment*	*Notes/Diagnosis*