# Who We Are Caring For

Name _____ Likes to be called _____

Date of birth _____ Lives at _____

## HEALTH AT A GLANCE

Diagnoses _____

_____

Allergies _____

Diet (soft, low sugar, thickened liquids...) _____

## GETTING AROUND

☐ Walks alone ☐ Cane ☐ Walker ☐ Wheelchair ☐ Bed-bound

☐ Needs 2 people to move

### SENSES

☐ Hearing aids ☐ Glasses ☐ Dentures ☐ Hard of hearing: speak to the ____ side

## IMPORTANT PAPERS

DNR / POLST is kept _____

Insurance cards are kept _____

Medication list is kept _____

## CALL FIRST

1. Name _____ Phone _____ Relationship _____

2. Name _____ Phone _____ Relationship _____

3. Name _____ Phone _____ Relationship _____

Doctor _____ Phone _____ Pharmacy _____

# A Normal Day

What usually happens, hour by hour. Helpers follow this so the day feels the same no matter who is here.

| TIME | WHAT USUALLY HAPPENS | TIPS FOR THE HELPER |
|---|---|---|
| **6 am** | | |
| **7 am** | | |
| **8 am** | | |
| **9 am** | | |
| **10 am** | | |
| **11 am** | | |
| **Noon** | | |
| **1 pm** | | |
| **2 pm** | | |
| **3 pm** | | |
| **4 pm** | | |
| **5 pm** | | |
| **6 pm** | | |
| **7 pm** | | |
| **8 pm** | | |
| **9 pm** | | |
| **10 pm** | | |
| **Overnight** | | |

# How They Like Things Done

The small things that make a big difference: the order, the words, the favorite cup.

**Waking up**

**Bathing & washing**

**Getting dressed**

**Eating & drinking**

**Taking medicine**

**Using the bathroom**

**Bedtime**

**What calms them**

**What upsets them**

# If This Happens, Do This

Write what works for this person, with the care team or doctor. **Chest pain, trouble breathing, a bad fall or no response: call 911 first.**

**If they fall**

_____

_____

Then call _____

**If they are confused or agitated**

_____

_____

Then call _____

**If they refuse their medicine**

_____

_____

Then call _____

**If they won't eat or drink**

_____

_____

Then call _____

**If they won't sleep or try to leave the house**

_____

_____

Then call _____

# Where Things Are

| | |
|---|---|
| **Medicines** | |
| **Medical supplies (gloves, wipes, pads)** | |
| **Clean sheets & towels** | |
| **Clean clothes** | |
| **Snacks & drinks they like** | |
| **Emergency kit & flashlight** | |
| **Spare key** | |
| **Thermostat** | |
| **Water shut-off & breaker box** | |
| **Trash & recycling day** | |
| **Other** | |

# Medication Schedule

Tick the times each medicine is due. On each day's page, the person on duty ticks "All given" and initials.

| MEDICINE | DOSE | WHAT IT'S FOR | 8 AM | NOON | 6 PM | BED | HOW TO GIVE IT |
|---|---|---|---|---|---|---|---|
| | | | ☐ | ☐ | ☐ | ☐ | |
| | | | ☐ | ☐ | ☐ | ☐ | |
| | | | ☐ | ☐ | ☐ | ☐ | |
| | | | ☐ | ☐ | ☐ | ☐ | |
| | | | ☐ | ☐ | ☐ | ☐ | |
| | | | ☐ | ☐ | ☐ | ☐ | |
| | | | ☐ | ☐ | ☐ | ☐ | |
| | | | ☐ | ☐ | ☐ | ☐ | |
| | | | ☐ | ☐ | ☐ | ☐ | |
| | | | ☐ | ☐ | ☐ | ☐ | |

**CHANGES**

# The Care Team

| NAME | PHONE | RELATIONSHIP / AGENCY | USUALLY COVERS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |