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

WEEKLY TEAM CHECK-IN

Week of _____ **Filled in by** _____

Helper tip: Write the handover note before you leave, even if nothing happened. "Quiet day, ate well" tells the next person a lot.

WHAT CHANGED THIS WEEK

_____

_____

_____

_____

QUESTIONS FOR THE DOCTOR

_____

_____

_____

_____

SUPPLIES TO BUY

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

WHO COVERS NEXT WEEK

	MON	TUE	WED	THU	FRI	SAT	SUN
1st Shift							
2nd Shift							
3rd Shift							

Date _____ Mon Tue Wed Thu Fri Sat Sun

Appointment today _____ **Time** _____

	1ST SHIFT	2ND SHIFT	3RD SHIFT
Who's on	_____ Time ____ to ____	_____ Time ____ to ____	_____ Time ____ to ____
Medicines	☐ All given ☐ Missed / refused Write which below	☐ All given ☐ Missed / refused Write which below	☐ All given ☐ Missed / refused Write which below
Ate	None Some Most All	None Some Most All	None Some Most All
Drank	Cups: ____	Cups: ____	Cups: ____
Bathroom	Urine # ___ BM # ___ ☐ Accident	Urine # ___ BM # ___ ☐ Accident	Urine # ___ BM # ___ ☐ Accident
Personal care	☐ Washed ☐ Dressed ☐ Teeth Self Help Full help	☐ Washed ☐ Dressed ☐ Teeth Self Help Full help	☐ Washed ☐ Dressed ☐ Teeth Self Help Full help
Mood	Calm Okay Upset Confused	Calm Okay Upset Confused	Calm Okay Upset Confused
Pain (0 to 10)	____ Where: _____	____ Where: _____	____ Where: _____
Vitals	BP ___/___ Pulse ___ Sugar ___ Temp ___ O2 ___	BP ___/___ Pulse ___ Sugar ___ Temp ___ O2 ___	BP ___/___ Pulse ___ Sugar ___ Temp ___ O2 ___
Sleep	Slept well Restless Up ___ times	Slept well Restless Up ___ times	Slept well Restless Up ___ times
Up & moving	☐ Walked ☐ Turned ☐ Rested	☐ Walked ☐ Turned ☐ Rested	☐ Walked ☐ Turned ☐ Rested
Signature			

WHAT THE NEXT PERSON NEEDS TO KNOW

_____

_____

_____

Visitors / calls _____ **Supplies needed** _____

INCIDENT & FALL LOG

Falls, injuries, medicine mistakes or anything unusual. Write it the same day, and tell the family.

Date _____ **Time** _____ **Caregiver** _____

☐ Fall ☐ Injury / bruise ☐ Medicine error ☐ Wandering ☐ Other

What happened _____

_____

What we did _____

Who was called _____

Date _____ **Time** _____ **Caregiver** _____

☐ Fall ☐ Injury / bruise ☐ Medicine error ☐ Wandering ☐ Other

What happened _____

_____

What we did _____

Who was called _____

Date _____ **Time** _____ **Caregiver** _____

☐ Fall ☐ Injury / bruise ☐ Medicine error ☐ Wandering ☐ Other

What happened _____

_____

What we did _____

Who was called _____