Caregiver Emergency Readiness Guide

Eastern Carolina Council
Area Agency on Aging

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Photo Identification

Complete this form in **pencil** and update document frequently.

Care Recipient Name/Older Adults Name: _____

Place current photo here

Caregiver Name/Older Adults Name: _____

Place current photo here

Emergency Readiness Information

Individuals Information

Name of care recipient: _____ *Age:* _____

Nick Names: _____

Primary Address: _____

Primary Caregiver: _____ *Relationship:* _____

Caregivers Address: _____

Caregivers Home phone: _____ *Cell:* _____

Emergency Contact/Caregiver:

Name: _____ *Relationship:* _____

Address: _____

Phone: Home: _____ *Cell:* _____

Hours of Care: _____

Alternate Contact/Caregivers:

1. *Name:* _____ *Relationship:* _____

   Address: _____

   Phone: Home: _____ *Cell:* _____

   Hours of Care: _____

2. *Name:* _____ *Relationship:* _____

   Address: _____

   Phone: Home: _____ *Cell:* _____

   Hours of Care: _____

Others willing to assist and nearest relatives to notify:

1. *Name:* _____ *Relationship:* _____

   Address: _____ *Phone: Home:* _____

2. *Name:* _____ *Relationship:* _____

   Address: _____ *Phone: Home:* _____

Advance Directives

Dose the individual have a living will? **Yes** **NO**

Location of original documents: _____

Filed with: _____

Address: _____

Phone(s): (home): _____ *(Cell):* _____

Individuals Code Status: *Full Code* *DNR (Do Not Resuscitate) Location of Original Document:* _____

Healthcare Surrogate or Power of Attorney for Health Care: **Yes** **No**

Location of original documents: _____

1. *Contact:* _____ *Relationship:* _____
   Address: _____
   Phone: _____ *Cell:* _____
2. *Contact:* _____ *Relationship:* _____
   Address: _____
   Phone: _____ *Cell:* _____
3. *Contact:* _____ *Relationship:* _____
   Address: _____
   Phone: _____ *Cell:* _____

Financial surrogate or Power of Attorney for financial affairs: **Yes** **No**

Location of Original Documents: _____

1. *Contact:* _____ *Relationship:* _____
   Address: _____
   Phone: _____ *Cell:* _____
2. *Contact:* _____ *Relationship:* _____
   Address: _____
   Phone: _____ *Cell:* _____
3. *Contact:* _____ *Relationship:* _____
   Address: _____
   Phone: _____ *Cell:* _____

General or Special Power of Attorney **Yes** **No**

Location of original documents: _____

1. *Contact:* _____ *Relationship:* _____
   Address: _____
   Phone: _____ *Cell:* _____

Healthcare and Services

The person with dementia/Alzheimer is currently receiving services from the following agency/agencies

1. ***Agency***: _____
   Contact: _____
   Services receiving: _____
   Phone: _____ *City:* _____
   Notes: _____
2. ***Agency***: _____
   Contact: _____
   Services receiving: _____
   Phone: _____ *City:* _____
   Notes: _____
3. ***Agency***: _____
   Contact: _____
   Services receiving: _____
   Phone: _____ *City:* _____
   Notes: _____

Medical Equipment Needs:

Communicates by:	*Speaking ( )*	*Gesture ( )*	*Pictures ( )*
Catheter ( )	*Wheelchair ( )*	*Hearing Aid R ( )*	*Hearing Aid L ( )*
Colostomy ( )	*Prosthesis ( )*	*Cane ( )*	*Walker ( )*
Crutch's ( )	*Can Speak ( )*	*Can Write ( )*	_____ ( )
_____ ( )	_____ ( )	_____ ( )	_____ ( )

Vision	R	L	Comment:	**Hearing**	R	L	Comment:
Good	( )	( )	_____	Good	( )	( )	_____
Limited	( )	( )	_____	Limited	( )	( )	_____
Blind	( )	( )	_____	Blind	( )	( )	_____
Glasses	( )	( )	_____	Deaf	( )	( )	_____
Contacts	( )	( )	_____	Aides	( )	( )	_____
Other: _____	( )	( )	_____	Other: _____	( )	( )	_____

Medical

Primary Care Physician: _____

Phone: _____

Address: _____

Medical Conditions	**Y**	**N**	**Physician**	**Phone:**
Alzheimer's disease	( )	( )	_____	_____
Alcoholism	( )	( )	_____	_____
Amputation	( )	( )	_____	_____
Arthritis	( )	( )	_____	_____
Asthma	( )	( )	_____	_____
COPD	( )	( )	_____	_____
Cancer	( )	( )	_____	_____
Colitis	( )	( )	_____	_____
Dentures/Partials	( )	( )	_____	_____
Diabetes (Type____)	( )	( )	_____	_____
Epilepsy/Seizures	( )	( )	_____	_____
Glaucoma	( )	( )	_____	_____
Heart disease	( )	( )	_____	_____
Hepatitis	( )	( )	_____	_____
High blood pressure	( )	( )	_____	_____
Low blood pressure	( )	( )	_____	_____
Multiple sclerosis	( )	( )	_____	_____
Pace maker	( )	( )	_____	_____
Parkinson 's disease	( )	( )	_____	_____
Prostate	( )	( )	_____	_____
Skeletal trauma	( )	( )	_____	_____
Thyroid	( )	( )	_____	_____
Tuberculosis	( )	( )	_____	_____
Ulcer	( )	( )	_____	_____
Other:				
Specify: _____	( )	( )	_____	_____
Specify: _____	( )	( )	_____	_____

Surgeries:

1. Type of surgery:_____ Date:_____
2. Type of surgery:_____ Date:_____
3. Type of surgery:_____ Date:_____
4. Type of surgery:_____ Date:_____
5. Type of surgery:_____ Date:_____

Nutritional Status

Does the care recipient have a diet prescribed by a physician? YES ( ) No ( )

If yes, describe: _____

_____

List of food allergies: _____

Does he/she normally have a good appetite? *YES ( )* *NO ( )*

Favorite Foods: _____

Least favorite foods: _____

Mealtimes:

Breakfast: _____ *Lunch:* _____ *Dinner:* _____ *Snack:* _____

Additional comments: _____

Functional Status Summary

Primary language: _____ *other known Languages:* _____

Specify what type of assistance is needed with the following:

	Yes	No	Comments:
Prepare meals	( )	( )	_____
Shop for personal items	( )	( )	_____
Manage own medications	( )	( )	_____
Manages own money	( )	( )	_____
Uses telephone independently	( )	( )	_____
Can do heavy housework	( )	( )	_____
Can do light housework	( )	( )	_____
Able to drive	( )	( )	_____
Eats independently	( )	( )	_____
Dresses independently	( )	( )	_____
Baths self independently	( )	( )	_____
Oral care independently	( )	( )	_____
Toilets independently	( )	( )	_____
Transfers into/out of bed/chair	( )	( )	_____
Ambulates independently	( )	( )	_____

Identification

Does the care recipient with dementia or other health concerns wear an ID bracelet or GPS type locator? YES ( ) NO ( )

If yes: Type and ID information: _____

Contact: _____ *Phone:* _____

Is the care recipient on the Special needs registration: YES ( ) NO ( )

If yes, what information has been given to the registry: _____

_____

Intellectual Functioning & Behaviors:

Reacts to own name:	Almost always ( )	Sometimes ( )	Never ( )
Knows caregiver:	Almost always ( )	Sometimes ( )	Never ( )
Knows location:	Almost always ( )	Sometimes ( )	Never ( )
Short term memory loss:	Almost always ( )	Sometime ( )	Never ( )
Long term memory loss	Almost always ( )	Sometime ( )	Never ( )
Sleep habits:	Sleeps most or all nights ( )	Sometimes wakes ( )	often wakes ( )

Insurance Information:

Date of Birth: ____/____/_____ *Medicare Effective Date:* _____

Insurance cards are located: _____

Secondary insurance (company/member i.d): _____

Medicare Part D (Pharmacy Insurance): _____

Primary Pharmacy:

Company name: _____

Address: _____

Phone: _____ *Fax:* _____

Exhibited Behaviors:

Check appropriate answers regarding behaviors:

Wanders-without purpose or regard for safety	*Never ( )*	*Sometimes ( )*	*Often ( )*
Pacing without purpose or regards to surroundings	*Never ( )*	*Sometimes ( )*	*Often ( )*
Has sundowners Behaviors (up throughout the evening time)	*Never ( )*	*Sometimes ( )*	*Often ( )*
Verbally threatens others:	*Never ( )*	*Sometimes ( )*	*Often ( )*
Physically tries to harm others	*Never ( )*	*Sometimes ( )*	*Often ( )*
Exposes him/herself in public	*Never ( )*	*Sometimes ( )*	*Often ( )*
Hallucinates/Delusions	*Never ( )*	*Sometimes ( )*	*Often ( )*
Exhibits quick mood shifts	*Never ( )*	*Sometimes ( )*	*Often ( )*
Depression	*Never ( )*	*Sometimes ( )*	*Often ( )*
Cries without cause	*Never ( )*	*Sometimes ( )*	*Often ( )*
Destroys things or is destructive	*Never ( )*	*Sometimes ( )*	*Often ( )*
Picking at self or at objects consistently	*Never ( )*	*Sometimes ( )*	*Often ( )*
Repetitive verbalization	*Never ( )*	*Sometimes ( )*	*Often ( )*
Refusal of care	*Never ( )*	*Sometimes ( )*	*Often ( )*
Misinterpretation of information	*Never ( )*	*Sometimes ( )*	*Often ( )*
Compulsive eating	*Never ( )*	*Sometimes ( )*	*Often ( )*
Suspicious or accusing behavior towards others	*Never ( )*	*Sometimes ( )*	*Often ( )*
Obsessive behaviors	*Never ( )*	*Sometimes ( )*	*Often ( )*
Abusive, self-berates or injures self	*Never ( )*	*Sometimes ( )*	*Often ( )*
Has increased anxiety at times	*Never ( )*	*Sometimes ( )*	*Often ( )*
Rummaging behaviors	*Never ( )*	*Sometimes ( )*	*Often ( )*
Dose not like to be touched by others	*Never ( )*	*Sometimes ( )*	*Often ( )*
Continually seeking touch by others	*Never ( )*	*Sometimes ( )*	*Often ( )*
Has sexual oriented inappropriate behaviors	*Never ( )*	*Sometimes ( )*	*Often ( )*
Hoards or steals small items	*Never ( )*	*Sometimes ( )*	*Often ( )*
Items of Interest: _____			
Other behaviors: _____	*Never ( )*	*Sometimes ( )*	*Often ( )*
Other behaviors: _____	*Never ( )*	*Sometimes ( )*	*Often ( )*

Activities

Check what best describes the care recipient's participation in the following activities:

1. *Reads the newspaper, books or magazines* *YES ( )* *NO ( )*
2. *Watches TV:* *YES ( )* *NO ( )*

   Favorite shows: _____

3. *Listens radio or music:* *YES ( )* *NO ( )*

   Favorite type of music: _____

4. *Works on a hobby:* *YES ( )* *NO ( )*

   Type of hobbies of interest: _____

   Comment: _____

5. *Attends Church (Religion:* _____*)* *YES ( )* *NO ( )*

   Comment: _____

6. *Enjoys naps (Time of day:* _____*)* *YES ( )* *NO ( )*

   Comment: _____

7. *Attends adult day care*

   Place and frequency/days per week: _____

   Name and phone number of facility: _____

8. *Senior Companion*

   Name: _____

   Hours/days of week of service _____

Daily routine/habits (please provide a brief description): _____

_____

_____

_____

_____

_____

Older Adults &Caregiver Check List; "To Go Bag"

Personal

_____ Socks

_____ Long pants

_____ Sweat shirts

_____ Spare pair of shoes

_____ Medication list

_____ Hair brush and comb

_____ Wet wipes

_____ Medications

_____ Current pictures of all family members

_____ Other: _____

_____ Other: _____

_____ Shirts

_____ Long sleeve shirts

_____ Under garments

_____ Deodorant

_____ Shaving items

_____ Dry shampoo

_____ Hand sanitizer

_____ Tooth paste & tooth brush

_____ Other: _____

_____ Other: _____

Animal

_____ Food

_____ Potty bags

_____ Blanket

_____ Shot records

_____ Medication list

_____ Hair brush and comb

_____ Other: _____

_____ Other: _____

_____ Leashes

_____ Towel

_____ Collar with ID

_____ Dog treats

_____ Toys

_____Veterinarians number

Older Adults & Caregiver Check List

_____ Drinking water (1 gallon/person/day)

_____ Food (non-perishable; ready to eat)

_____ Flashlight

_____ Portable radio

_____ Extra batteries

(ie: flashlight, hearing aids, ..)

_____ First aid kit

_____ Hand-operated can opener

_____ Light sticks

_____ Waterproof matches

_____ Cash or traveler's checks

_____ Duct tape

_____ Facial tissues

_____ Wet toweletts

_____ Scissors

_____ Hand sanitizer

_____ Phone chargers

_____ Rain gear

_____ Filter mask

_____ Garbage bags paper plates, cups

_____ Wrench & pliers

_____ Disinfectant

_____ Sun tan lotion

_____ Gallon zip Lock Bags

_____ Whistle (to signal for help)

_____ Utility knife

_____ Sensory items

(i.e. head phones, puzzles, games)

_____ Extra sets of Keys (house and car)

Other medical supplies:

1._____

2. _____

3. _____

Documents: *Seal in a water proof container*

_____ Insurance cards

_____ Medication list

_____ Advance directives

_____ Will

_____ Deeds

_____ Family contact phone sheet

_____ Emergency contact phone list

_____ Marriage certificate

_____ Passports

_____ Birth certificates

_____ Important medical documents

_____ Medical equipment

Documents/phone list

_____ Other: _____

_____ Other: _____

_____ Other: _____

All items should be stored together in an easily accessible location. You should annually review all items in your emergency kit and check all items with an expiration date, and replace as needed.

Personal Contact

Name:	Relationship:	Primary Phone:	Secondary Phone:
Electric Company	N/A		
Water Company	N/A		
Local Hospital	N/A		
Physician's Office	N/A		
Pharmacy	N/A		
Telephone Company	N/A		
Cable Company	N/A		
Department of Social Services	N/A		
Police/Steffi's office	N/A		

EasternCarolinaCouncil

Area Agency on Aging

January Brown; Human Services Planner-FCSP

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