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To Our Clients and Friends:

Re: **Care at Home Data Sheet**

We know many of our clients and friends are struggling with the care of an aging parent, ill spouse or child. Please take a moment to consider how much more difficult and stressful the situation may be if all the knowledge you possess about your ill family member was lost or misplaced.

Whatever the circumstances, we know that it is extremely important to keep good records of medication, treatments, doctor visits and other pertinent information in order to maintain control over the care of your loved one.

Accordingly, we are pleased to attached a five (5) page outline that may assist you in gathering and retaining pertinent information.

NOTES FOR CAREGIVERS

Family Member's Name: _____ Age: _____

Personality:

_____

_____

_____

_

_

_

_

Special Likes/Dislikes:

_____

_____

_____

_

_

_

Services Required:

_____

_____

_____

_

_

_

Special Procedures/Therapies Required:

_____

_____

_____

_

_

_

LEGAL MATTERS

Attorney:
_____

Documents located at:
_____

Power of Attorney Agent:
_____

Health Care Agent:
_____

DAILY SCHEDULE

Time Task Comments

Morning:
1. _____
2. _____
3. _____
4. _____
5. _____

Afternoon:
1. _____
2. _____
3. _____
4. _____
5. _____

Evening:

1. _____

2. _____

3. _____

4. _____

5. _____

CURRENT MEDICATIONS FOR _____

Family Member's Name

(include over the counter medications)

Medication Date Started Dosage Delivery Route Times Given By

_____

Notes/Side Effects _____

_____

Notes/Side Effects _____

_____

Notes/Side Effects _____

_____

Notes/Side Effects _____

_____

Notes/Side Effects _____

_____

Notes/Side Effects _____

EMERGENCY PHONE NUMBERS

Work/Cell #'s:_____

Other Family Members: _____

Physician(s): _____

Pharmacy: _____

Emergency back-up(s)/Caregiver(s): _____

Other: _____

ADDITIONAL NOTES

_____

_____

_____

_____

_____

_____

OTHER IMPORTANT INFORMATION/TELEPHONE NUMBERS

Family Member's Name: _____

Date of Birth: _____

Social Security Number: _____

Veterans #: _____

Maiden Name:_____

Providers/Contacts ***Telephone Numbers***

Life Insurance Company: _____

Policy Number: _____

Contact Person: _____

Long Term Care Insurance Company:

_____

Policy Number: _____

Contact Person: _____

Medicaid ID Number (if applicable):

_____

Medicare ID Number (if applicable):
_____

Case Manager:
_____
Primary Doctor:
_____

Specialists: _____

Clinics: _____

Pharmacy:
_____

Home Care Agency: _____

Individual Nurses/Contacts for Emergencies
_____
_____
_____

Transportation: _____

School: _____

Fire Department: _____

Police Department _____

Emergency Caregiver(s):
_____

NURSE INFORMATION

Nurse _____ Tele No. _____ Emergency Availability
_____

Days/Hours Available _____ RN/LPN Lic #
_____

Comments

Nurse _____ Tele No. _____ Emergency Availability _____

Days/Hours Available _____ RN/LPN Lic # _____

Comments

Nurse _____ Tele No. _____ Emergency Availability _____

Days/Hours Available _____ RN/LPN Lic # _____

Comments
