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
## 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

**Does the individual have a living will?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>NO</th>
</tr>
</thead>
</table>

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 ( )

**Equipment Needs:**

- Catheter ( )
- Wheelchair ( )
- Hearing Aid R ( )
- Hearing Aid L ( )
- Prosthesis ( )
- Can Speak ( )
- Can Write ( )
- Cane ( )
- Walker ( )
- Crutch's ( )
- ______ ( )
- ______( )
- ______( )
- ______( )

---

**Vision**

- R ( )
- L ( )

- **Comment:** ________________

**Hearing**

- R ( )
- L ( )

- **Comment:** ________________

---

**Contacts**

- ______ ( )

**Other:** ______ ( ) ( )

**Comment:** ________________
Medical

Primary Care Physician: ________________________________________________________________

Phone: ______________________________________________________________________________

Address: ______________________________________________________________________________

<table>
<thead>
<tr>
<th>Medical Conditions</th>
<th>Y</th>
<th>N</th>
<th>Physician</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s disease</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcoholism</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amputation</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colitis</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentures/Partials</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes (Type__)</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy/Seizures</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glaucoma</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart disease</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low blood pressure</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple sclerosis</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pace maker</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parkinson’s disease</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skeletal trauma</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulcer</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify:</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify:</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:____________

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:

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

React 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 ( ) Sometimes ( ) Never ( )

Long term memory loss: Almost always ( ) Sometimes ( ) 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: ___________________________
<table>
<thead>
<tr>
<th>Exhibited Behaviors:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Check appropriate answers regarding behaviors:</strong></td>
</tr>
<tr>
<td>Wander without purpose or regard for safety</td>
</tr>
<tr>
<td>Pacing without purpose or regards to surroundings</td>
</tr>
<tr>
<td>Has sundowners Behaviors (up throughout the evening time)</td>
</tr>
<tr>
<td>Verbally threatens others:</td>
</tr>
<tr>
<td>Physically tries to harm others</td>
</tr>
<tr>
<td>Exposes him/herself in public</td>
</tr>
<tr>
<td>Hallucinates/Delusions</td>
</tr>
<tr>
<td>Exhibits quick mood shifts</td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Cries without cause</td>
</tr>
<tr>
<td>Destroys things or is destructive</td>
</tr>
<tr>
<td>Picking at self or at objects consistently</td>
</tr>
<tr>
<td>Repetitive verbalization</td>
</tr>
<tr>
<td>Refusal of care</td>
</tr>
<tr>
<td>Misinterpretation of information</td>
</tr>
<tr>
<td>Compulsive eating</td>
</tr>
<tr>
<td>Suspicious or accusing behavior towards others</td>
</tr>
<tr>
<td>Obsessive behaviors</td>
</tr>
<tr>
<td>Abusive, self-berates or injures self</td>
</tr>
<tr>
<td>Has increased anxiety at times</td>
</tr>
<tr>
<td>Rummaging behaviors</td>
</tr>
<tr>
<td>Dose not like to be touched by others</td>
</tr>
<tr>
<td>Continually seeking touch by others</td>
</tr>
<tr>
<td>Has sexual oriented inappropriate behaviors</td>
</tr>
<tr>
<td>Hoards or steals small items</td>
</tr>
<tr>
<td><strong>Items of Interest:</strong></td>
</tr>
<tr>
<td><strong>Other behaviors:</strong></td>
</tr>
<tr>
<td><strong>Other behaviors:</strong></td>
</tr>
</tbody>
</table>
## 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

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socks</td>
<td></td>
</tr>
<tr>
<td>Long pants</td>
<td></td>
</tr>
<tr>
<td>Long sleeve shirts</td>
<td></td>
</tr>
<tr>
<td>Sweatshirts</td>
<td></td>
</tr>
<tr>
<td>Under garments</td>
<td></td>
</tr>
<tr>
<td>Spare pair of shoes</td>
<td></td>
</tr>
<tr>
<td>Deodorant</td>
<td></td>
</tr>
<tr>
<td>Medication list</td>
<td></td>
</tr>
<tr>
<td>Shaving items</td>
<td></td>
</tr>
<tr>
<td>Hairbrush and comb</td>
<td></td>
</tr>
<tr>
<td>Dry shampoo</td>
<td></td>
</tr>
<tr>
<td>Wet wipes</td>
<td></td>
</tr>
<tr>
<td>Hand sanitizer</td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td></td>
</tr>
<tr>
<td>Toothpaste &amp; tooth brush</td>
<td></td>
</tr>
<tr>
<td>Current pictures of all family members</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

## Animal

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td></td>
</tr>
<tr>
<td>Leashes</td>
<td></td>
</tr>
<tr>
<td>Potty bags</td>
<td></td>
</tr>
<tr>
<td>Towel</td>
<td></td>
</tr>
<tr>
<td>Blanket</td>
<td></td>
</tr>
<tr>
<td>Collar with ID</td>
<td></td>
</tr>
<tr>
<td>Shot records</td>
<td></td>
</tr>
<tr>
<td>Dog treats</td>
<td></td>
</tr>
<tr>
<td>Medication list</td>
<td></td>
</tr>
<tr>
<td>Toys</td>
<td></td>
</tr>
<tr>
<td>Hairbrush and comb</td>
<td></td>
</tr>
<tr>
<td>Veterinarians number</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

---
Older Adults & Caregiver Check List

_____ Drinking water (1 gallon/person/day)
_____ Food (non-perishable; ready to eat)
_____ Flashlight
_____ Portable radio
_____ Extra batteries
  (i.e.: 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.
<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Primary Phone</th>
<th>Secondary Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electric Company</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water Company</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Hospital</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone Company</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cable Company</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department of Social Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police/Sheriff’s office</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Alzheimer’s Association**: [www.alz.org; 1-800-272-3900](http://www.alz.org)

Information and support for people with Alzheimer’s disease and their caregivers. Operates a 24/7 helpline and care navigator tools.

**Alzheimer’s North Carolina**: [www.alznc.org; 1-800-228-8738](http://www.alznc.org)

Alzheimer’s North Carolina is dedicated to providing education, support and services to individuals with dementia, their families, health care professionals and the public while raising awareness and funding for research of a cause(s), treatment, prevention and cure for Alzheimer's disease and related dementias.

**ARCH Respite Network**: [www.archrespite.org](http://www.archrespite.org)

Find programs and services that allow caregivers to get a break from caring for a loved one.

**Caregiver Teleconnection**: [www.caregiversos.org/caregiver-teleconnection/; 1-866-390-6491](http://www.caregiversos.org/caregiver-teleconnection/)

The Caregiver Teleconnection is a free, safe, and confidential program that uses the telephone to connect family caregivers with trusted professionals and other caregiver. Offers caregiver training, assistance, and support.

**Duke Alzheimer’s Family Caregiver Support Program**: [www.geri.duke.edu/service/dfsp/about.htm](http://www.geri.duke.edu/service/dfsp/about.htm)

A source for help with Alzheimer’s, memory disorders and elder care decisions. The Duke Family Support Program serves families and professionals concerned about or caring for persons with memory disorders in North Carolina, and Duke Employees seeking help with elder care decisions.

**Eldercare Locator**: [www.eldercare.gov, 1-800-677-1116](http://www.eldercare.gov)

Connects caregivers to local services and resources for older adults and adults with disabilities across the United States.

**Medicare**: [www.medicare.gov/caregivers; 1-800-Medicare](http://www.medicare.gov)

**National Alliance for Caregiving**: [www.caregiving.org](http://www.caregiving.org)

A coalition of national organizations focused on family caregiving issues.

**NC Medicaid**: [www.ncdhss.gov/dma/medicaid/](http://www.ncdhss.gov/dma/medicaid/)

**NC Seniors’ Health Insurance Program**: [www.ncshiip.com, 1-800-443-9354](http://www.ncshiip.com)

A program that offers one-on-one insurance counselling and assistance to people with Medicare and their families.

**Parkinson’s Association of the Carolinas**: [www.parkinsonassociation.org](http://www.parkinsonassociation.org)

Resource for individuals and their families living in the Carolinas who are affected by Parkinson’s disease.

**Social Security Administration**: [1-800-772-1213](http://www.ssa.gov)


Resources for individuals to include fitness, health, caregiving, etc...

**Veterans Administration**: [www.caregiver.va.gov, 1-855-260-3274](http://www.caregiver.va.gov)