Caregiver Emergency Readiness Guide

EasternCarolinaCouncil
Area Agency on Aging

PO Box 1717 New Bern, NC 28560• Phone: 252.638.3185• Website: www.eccog.org

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: _____DOB: _____

Nick Name(s): _____

Primary Address: _____

Primary Caregiver: _____Relationship: _____

Caregivers Address: _____

Caregivers Home phone: _____ Cell: _____

Emergency Contact/Caregiver:

Name: _____Relationship: _____

Address: _____

Phone: Home: _____ Cell: _____

Alternate Contact/Caregivers:

1. Name: _____Relationship: _____

   Address: _____ Phone: _____

2. Name: _____Relationship: _____

   Address: _____ Phone: _____

Advance Directives

I have a living will? ☐ **Yes** ☐ **NO**

Location of my original documents: _____

Filed with (lawyer, county, etc.): _____

Address: _____

Phone Number: _____

Individuals Code Status: ☐**Full Code** ☐ **DNR (Do Not Resuscitate)**

Location of Original Document: _____

Legal Documents

Healthcare Surrogate or Power of Attorney for Health Care: ☐ **Yes** ☐ **No**
Location of original documents: _____

1. POA: _____Relationship: _____
   Address: _____
   Phone: _____ Cell: _____ Work: _____
2. POA: _____Relationship: _____
   Address: _____
   Phone: _____ Cell: _____ Work: _____
3. POA: _____Relationship: _____
   Address: _____
   Phone: _____ Cell: _____ Work: _____

Financial surrogate or Power of Attorney for financial affairs: ☐ **Yes** ☐ **No**
Location of Original Documents: _____

1. POA: _____Relationship: _____
   Address: _____
   Phone: _____ Cell: _____ Work: _____
2. POA: _____Relationship: _____
   Address: _____
   Phone: _____ Cell: _____ Work: _____
3. POA: _____Relationship: _____
   Address: _____
   Phone: _____ Cell: _____ Work: _____

General or Special Power of Attorney ☐ **Yes** ☐ **No**
Location of Original Documents: _____

1. POA: _____Relationship: _____
   Address: _____
   Phone: _____ Cell: _____ Work: _____
2. POA: _____Relationship: _____
   Address: _____
   Phone: _____ Cell: _____ Work: _____

Insurance Information:

Insurance cards are located: _____

Medicare Part A Effective Date: _____ Medicare Part B Effective Date: _____

Secondary insurance (company/member id): _____

Medicare Part D (Pharmacy Insurance): _____

Services

Individual is currently receiving services from the following agency/agencies:

☐ **Home Delivered meals**; Agency: _____ Phone: _____

Time: _____ Days: ☐ Mon. ☐ Tue. ☐ Wed. ☐ Thur. ☐ Fri.

Comments: _____

☐ **Home Health**; Agency: _____ Phone: _____

Services Provided: _____ Time: _____

Days: ☐ Sun. ☐ Mon. ☐ Tue. ☐ Wed. ☐ Thur. ☐ Fri. ☐ Sat.

Comments: _____

☐ **Therapy**; Agency: _____ Phone: _____

Service Provided: _____ Time: _____

Days: ☐ Sun. ☐ Mon. ☐ Tue. ☐ Wed. ☐ Thur. ☐ Fri. ☐ Sat.

Comments: _____

☐ **Hospice**; Agency: _____ Phone: _____

Service Provided: _____ Time: _____

Days: ☐ Sun. ☐ Mon. ☐ Tue. ☐ Wed. ☐ Thur. ☐ Fri. ☐ Sat.

Comments: _____

☐ **Other**; Agency: _____ Phone: _____

Service Provided: _____ Time: _____

Days: ☐ Sun. ☐ Mon. ☐ Tue. ☐ Wed. ☐ Thur. ☐ Fri. ☐ Sat.

Comments: _____

Communication

Primary language: _____ Secondary Language: _____

Other Languages known: _____

Communicates by:

☐ Speaking ☐ Can Write ☐ Communicates by Gesture

☐ Pictures Board ☐ Sign language ☐ Other: _____

Vision	Right	Left	Hearing	Right	Left
Good	☐	☐	Good	☐	☐
Limited	☐	☐	Limited	☐	☐
Blind	☐	☐	Deaf	☐	☐
Color Blind	☐	☐	Hearing Aides	☐	☐

Wears: ☐ Glasses ☐ Contacts

Medical Equipment Needs:

Medical Equipment:

☐ Wheelchair ☐ Walker ☐ Cane ☐ Crutch's

☐ Catheter ☐ Colostomy ☐ Prosthesis ☐Oxygen Equipment

☐ Shower Chair ☐ Hoyer Lift ☐ Lift Chair/Recliner

☐ Other: _____ ☐ Other: _____

Medical

Primary Care Doctor: _____ Phone: _____

Address: _____

Eye Doctor: _____ Phone: _____

Address: _____

Pharmacy: _____ Phone: _____

Address: _____

Specialist: _____ Phone: _____

Address: _____

Medical

Medical Conditions	Yes	No	Physician/Phone/Comments
Alcoholism			
Amputation			
Anxiety Disorder			
Arthritis			
Asthma			
Cancer			
COPD			
Dementia, Type: _____			
Dentures/Partials			
Depression			
Diabetes's, type: _____			
Epilepsy/seizures			
Glaucoma			
Heart condition/disease			
Hepatitis, type: _____			
High Blood pressure			
Low blood pressure			
Mental Health diagnosis, type:			
Multiple sclerosis			
OCD			
Pace maker			
Parkinson's disease			
Prostate issues			
PTSD			
Skeletal trauma			
Thyroid, type:			
Tuberculosis			
Ulcer			
Other; specify: _____			
Other; specify: _____			
Other; specify: _____			
Other; specify: _____			

Notes:

Surgery History

1. Type of surgery: _____Date:_____

   Location of Surgery/Physician: _____

   Comments: _____

2. Type of surgery: _____Date:_____

   Location of Surgery/Physician: _____

   Comments: _____

3. Type of surgery: _____Date:_____

   Location of Surgery/Physician: _____

   Comments: _____

4. Type of surgery: _____Date:_____

   Location of Surgery/Physician: _____

   Comments: _____

5. Type of surgery: _____Date:_____

   Location of Surgery/Physician: _____

   Comments: _____

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 Assessment

Specify what type of assistance is needed with the following:

Task	Yes	No	Comments
Prepares meals			
Manages own money			
Manages own medications			
Shops for personal items			
Uses the telephone independently			
Can do heavy housework			
Can do light housework			
Can drive independently			
Eats independently			
Dresses independently			
Baths self independently			
Completes oral care independently			
Toilets self independently			
Transfers into/out of bed/chair			
Ambulates independently			

Intellectual Functioning & Behaviors:

Reacts to own name	☐ Never	☐ Sometimes	☐ Often
Knows caregiver/family	☐ Never	☐ Sometimes	☐ Often
Knows location	☐ Never	☐ Sometimes	☐ Often
Can manage finances	☐ Never	☐ Sometimes	☐ Often
Exhibits Short-term memory loss	☐ Never	☐ Sometimes	☐ Often
Exhibits long-term memory loss	☐ Never	☐ Sometimes	☐ Often
Sleeps through the night	☐ Never	☐ Sometimes	☐ Often

Identification

Identification	Yes	No	Comments
Has a medical ID bracelet/neckless			
Has a medical alert system			
Wears a wearable GPS tracking locator			
Care recipient is registered with the county special needs registry			

Exhibited Behaviors:

Check all appropriate answers regarding personal behaviors:

Likes bathing routine, type: _____	☐ Never	☐ Sometimes	☐ Often
Wanders-without purpose or regards to safety	☐ Never	☐ Sometimes	☐ Often
Paces without purpose or regards to surroundings	☐ Never	☐ Sometimes	☐ Often
Has sundowners' behaviors	☐ 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 swings	☐ Never	☐ Sometimes	☐ Often
Depression	☐ Never	☐ Sometimes	☐ Often
Cries without reason	☐ Never	☐ Sometimes	☐ Often
Destroys things or is destructive	☐ Never	☐ Sometimes	☐ Often
Picking at self or 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 behaviors towards others	☐ Never	☐ Sometimes	☐ Often
Obsessive behaviors	☐ Never	☐ Sometimes	☐ Often
Abusive, self-berates or injures self	☐ Never	☐ Sometimes	☐ Often
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
Sexual oriented inappropriate behaviors	☐ Never	☐ Sometimes	☐ Often
Hordes or steals items	☐ Never	☐ Sometimes	☐ Often
Rocks to calm self	☐ Never	☐ Sometimes	☐ Often
Interacts with baby doll or stuff animal	☐ Never	☐ Sometimes	☐ Often
Talks to self	☐ Never	☐ Sometimes	☐ Often
Other behaviors:_____	☐ Never	☐ Sometimes	☐ Often
Other behaviors:_____	☐ Never	☐ Sometimes	☐ Often
Other behaviors:_____	☐ Never	☐ Sometimes	☐ Often
Other behaviors:_____	☐ Never	☐ Sometimes	☐ Often
Other behaviors:_____	☐ Never	☐ Sometimes	☐ Often

Activities

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

Activity	Yes	No	Comments
Enjoys Haircuts/hair salon			
Wears make-up daily			
Enjoys nail care/nails painted			
Reads the newspaper, books, or magazines			
Watches T.V.			*Favorite Shows:*
Listens to the radio or music			*Favorite music:*
Engages with busy blanket			
Enjoys hobbies			*Type:*
Attends Church			*Religion:*
Takes naps regularly			*Time:*
Enjoys socializing			
Attends an adult daycare program			
Attends the senior center			
Attends a group or organization			

Senior companion or respite provider

Name: _____Phone: _____

Hours/days of week of service:_____

Daily routine/habits (*please provide a brief description to include likes and dislikes*.):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Long Term Care

My preferences for long term care facilities are:

Assisted Living Facility Choices

1. Facility Name: _____
   Facility Address: _____
   Facility Phone Number: _____
2. Facility Name: _____
   Facility Address: _____
   Facility Phone Number: _____
3. Facility Name: _____
   Facility Address: _____
   Facility Phone Number: _____

Memory Care Facility Choices

1. Facility Name: _____
   Facility Address: _____
   Facility Phone Number: _____
2. Facility Name: _____
   Facility Address: _____
   Facility Phone Number: _____
3. Facility Name: _____
   Facility Address: _____
   Facility Phone Number: _____

Skilled Nursing and Rehabilitation Facilities

4. Facility Name: _____
   Facility Address: _____
   Facility Phone Number: _____
5. Facility Name: _____
   Facility Address: _____
   Facility Phone Number: _____
6. Facility Name: _____
   Facility Address: _____
   Facility Phone Number: _____

Personal Contact List

Name:	Relationship:	Primary Phone:	Secondary Phone:
Cable Company	N/A		
Department of Social Services	N/A		
Electric Company	N/A		
FEMA	N/A	1-800-621-3362	
Home Insurance Company	N/A		
Local Hospital	N/A		
Medicare	N/A	1-800-633-4227	
Pharmacy	N/A		
Physician's Office	N/A		
Police/Sheriff's office	N/A		
Telephone Company	N/A		
Trash Company	N/A		
Vehicle Insurance Company	N/A		
Water Company	N/A		

My wish's, what you need to know:

Notes:

My Evacuation Plan Is:

If I leave my home I will go to:

My Zone: _____

(*https://www.ncdps.gov/our-organization/emergency-management/emergency-preparedness/know-your-zone*)

My local shelter is located at: _____

Route: _____

Notes: _____

Primary Location:

Address: _____

Route: _____

Notes: _____

Secondary Location:

Address: _____

Route: _____

Notes: _____

Third Location:

Address: _____

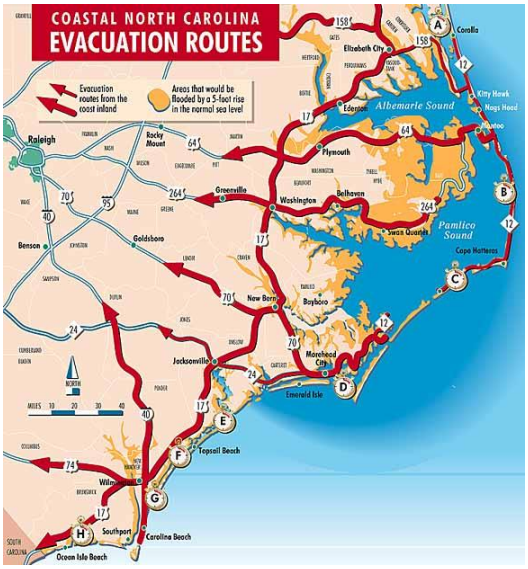
Route: _____

Resources:

*American Red Cross: https://www.redcross.org/

*FEMA: https://www.fema.gov/

*ReadyNC: https://www.readync.org/



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

Personal "To Go Bag"

Provide enough of each item for each person & keep in your vehicle

- ☐ **Socks**
- ☐ **Shirts**
- ☐ **Long pants**
- ☐ **Under garments**
- ☐ **Deodorant**
- ☐ **Spare pair of shoes**
- ☐ **Medication list**
- ☐ **Shaving items**
- ☐ **Hair brush/comb**
- ☐ **Dry shampoo**
- ☐ **Wet wipes**
- ☐ **Hand sanitizer**
- ☐ **Medications**
- ☐ **Wall Chargers**
- ☐ **Spare glasses**
- ☐ **Hearing aid batteries**
- ☐ **Tooth paste**
- ☐ **Tooth brush**
- ☐ **Suntan lotion**
- ☐ **Paper/pen**
- ☐ **Comfort items**
- ☐ **Blanket**
- ☐ **Bottle of water**
- ☐ **Flash light**
- ☐ **Phone list**
- ☐ **Towel**
- ☐ **Chap stick**
- ☐ **Book**
- ☐ **Universal screw driver**
- ☐ **Nail file, clippers**
- ☐ **Current pictures of all family members**
- ☐ **Other: _____**
- ☐ **Other: _____**
- ☐ **Other: _____**

Animal "To Go Bag"

- ☐ **Food**
- ☐ **Leashes**
- ☐ **Potty bags**
- ☐ **Towel**
- ☐ **Blanket**
- ☐ **Collar with ID**
- ☐ **Shot records**
- ☐ **Dog treats**
- ☐ **Medication list**
- ☐ **Toys**
- ☐ **Veterinarians info.**
- ☐ **Brush/comb**
- ☐ **Other: _____**
- ☐ **Other: _____**

Older Adults & Caregiver
Emergency Kit Check List Emergency Kit

- ☐ Drinking water (1 gallon/person/day)
- ☐ Food (non-perishable; 5-day supply per person)
- ☐ Portable radio
- ☐ Extra batteries (AA/AAA, hearing aids)
- ☐ Cash or traveler's checks
- ☐ Facial tissues
- ☐ Sensory Items (i.e. head phones, puzzles, games)
- ☐ Phone chargers (Care & Wall)
- ☐ Garbage bags paper plates, cups
- ☐ Whistle (to signal for help)
- ☐ Supply of medications
- ☐ Extra sets of Keys (house/car)
- ☐ Other: _____
- ☐ Other: _____
- ☐ First aid kit
- ☐ Flashlight/light sticks
- ☐ Waterproof matches
- ☐ Hand-operated can opener
- ☐ Wet towelettes
- ☐ Filter mask
- ☐ Gallon zip Lock Bags
- ☐ Wrench & pliers
- ☐ Sun tan lotion
- ☐ Medical supplies
- ☐Solar phone charger
- ☐ Other: _____
- ☐ Other: _____
- ☐ Duct tape
- ☐ Rain gear
- ☐ Scissors
- ☐ Sanitizer
- ☐ Blanket
- ☐ Local Map
- ☐ Disinfectant
- ☐ Bug spray
- ☐ Utility knife
- ☐ First-aid kit
- ☐ Pet supplies
- ☐ Other: _____
- ☐ Other: _____

Documents: *Seal in a water proof container*

- ☐ Insurance cards
- ☐ Deeds
- ☐ Marriage certificate
- ☐ Birth certificates
- ☐ Home Owners Policy
- ☐ Important medical documents
- ☐ Other: _____
- ☐ Other: _____
- ☐ Medication list
- ☐ Car Insurance Policy
- ☐ Divorce Documents
- ☐ Check Books
- ☐ Written family phone list
- ☐ Other: _____
- ☐ Other: _____
- ☐ Advance directives
- ☐ Passports
- ☐ Social Security Card
- ☐ Pet Records/shot history
- ☐ Home utilities phone list
- ☐ Other: _____
- ☐ Other: _____

*****All items should be stored together in an easily accessible location.*****

Inventory stock annually and review items expiration date and replace as needed.

Caregiver & Older Adult Resources

***Alzheimer's Association:** www.alz.org; **1-800-272-3900**

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**

Alzheimer's North Carolina is dedicated to providing education, support and services to individuals with dementia, their families, health care professionals and the general 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

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**

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

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**

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

***Eastern Carolina Council on Aging: www.eccog.org**

The ECC website offers information on local support, the elder locator with up to date regional support services, and agency information and services.

***Medicare-** www.medicare.gov/caregivers; **1-800-Medicare**

***National Alliance for Caregiving:** www.caregiveing.org

A coalition of national organizations focused on family caregiving issues.

***NC Medicaid:** www.ncdhss.gov/dma/medicaid/

***NC Seniors' Health Insurance Program:** www.ncshiip.com, **1-800-443-9354**

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

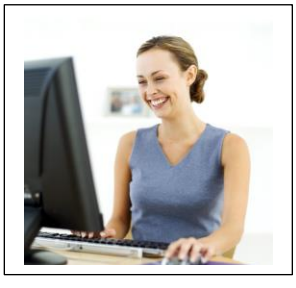
Resource for individuals and their families living in the Carolinas who are affected by Parkinson's disease

***Social Security Administration-1-800-772-1213**

***US Department of Health and Human Services: www.nia.nih.gov/health/publications**

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

***Veterans Administration:** www.caregiver.va.gov, **1-855-260-3274**



EasternCarolinaCouncil

Area Agency on Aging

January Brown; Human Services Planner-FCSP

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