

Caregiver Emergency Readiness Guide



Eastern Carolina Council

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: _____ 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:

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

<u>Vision</u>	<u>R</u>	<u>L</u>	<u>Comment:</u>	<u>Hearing</u>	<u>R</u>	<u>L</u>	<u>Comment:</u>
Good	()	()	_____	Good	()	()	_____
Limited	()	()	_____	Limited	()	()	_____
Blind	()	()	_____	Blind	()	()	_____
Glasses	()	()	_____	Deaf	()	()	_____
Contacts	()	()	_____	Aides	()	()	_____
Other: _____	()	()	_____	Other: _____	()	()	_____

Medical

Primary Care Physician: _____

Phone: _____

Address: _____

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

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:

	<u>Yes</u>	<u>No</u>	<u>Comments:</u>
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:

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

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.

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.ncshipp.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**

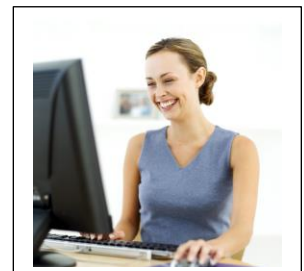
Resource for individuals and their families living in the Carolinas who are affected by Parkinson's disease

***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**





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January Brown; Human Services Planner-FCSP

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