# Key Information About Your Loved One

Name:_____ Date of Birth: _____

Address: _____

Phone: (_____)_____ Cell: (_____)_____

***Emergency Contact Information:***

Name: _____ Relationship:_____

Phone: (_____)_____ Cell: (_____)_____

Contact Notes: _____

Name: _____ Relationship:_____

Phone: (_____)_____ Cell: (_____)_____

Contact Notes: _____

***Medical Information:***

Medical Conditions (memory loss / dementia / Alzheimer's, Parkinson's, diabetes, etc.):

_____

_____

Medical Equipment Needs: ☐ Glasses ☐ Hearing Aids ☐ Dentures ☐ Cane/Walker

☐ Wheelchair ☐ Oxygen ☐ Insulin ☐ Inhaler ☐ Medical ID/Alert ☐ Tube Feeding

Other_____

Known Allergies:_____

Primary Care Doctor:_____ Phone:(_____)_____

Preferred Hospital:_____ Phone:(_____)_____

Speciality Doctor:_____ Phone:(_____)_____

Pharmacy:_____Phone:(_____)_____

Pharmacy Address:_____

## ***Health Care Proxy / Agent***

*Person authorized to make decisions on medical treatment in the event of mental or physical incapacity*

Name: _____ Relationship:_____

Phone: (_____)_____ Cell: (_____)_____ Email:_____

Address:_____

Contact Instructions: _____

Document on file: _____

Physician signed Do Not Resuscitate (DNR) Order on File? ⬚ Yes ⬚ No

## ***Power of Attorney (POA)***

**Durable Power of Attorney (POA)? ☐ Yes ☐ No**

*POA – Legal authorization to handle the personal and financial affairs of another.*
*Durable POA- Remains in effect in the event of mental incapacity.*

Name: _____ Relationship:_____

Phone: (_____)_____ Cell: (_____)_____ Email:_____

Address:_____

Contact Instructions: _____

*Back Up Representative in the event that Representative Listed Above Cannot Serve:*

Name: _____ Relationship:_____

Phone: (_____)_____ Cell: (_____)_____ Email:_____

Document location:_____

**Healthcare Power of Attorney (POA)? ☐ Yes ☐ No**

⬚ Same as above representative (complete below if different)

Name: _____ Relationship:_____

Phone: (_____)_____ Cell: (_____)_____ Email:_____

Address:_____

Contact Instructions: _____

*Back Up Representative in the event that Representative Listed Above Cannot Serve:*

Name: _____ Relationship:_____

Phone: (_____)_____ Cell: (_____)_____ Email:_____

Document location:_____

***Conservator / Guardian***

*Court appointed person to handle the personal and financial matters of one deemed mentally incompetent.*

Name: _____ Relationship:_____
Phone: (_____)_____ Cell: (_____)_____ Email:_____

Address:_____

Contact Instructions: _____

Document on file with:_____

***Financial & Legal Information***

Primary Insurance Provider:_____ Policy #:_____

Medicare ID #:_____

Medicaid ID #: _____

*Primary Bank*:_____ Account #:_____

Website:_____ Login/Password:_____

*Accountant Firm*:_____ Phone: (_____)_____

Name: _____ Email:_____

*Financial Advisor Firm*: _____ Phone: (_____)_____

Name: _____ Email:_____

*Law Firm*: _____Phone: (_____)_____

Attorney Name: _____Email:_____

Other Financial / Legal Information:

_____

_____

_____

_____

# About My Loved One

Providing family and paid help with more information about your loved one may help the transition of care and create the best quality time.

Preferred Name / Nickname: _____

First Language:_____ Other Languages:_____

Date of Birth: _____ Place of Birth:_____

Places They Have Lived: _____

Religious Preference: _____

Military Veteran? ⬚ Yes ⬚ No Military Notes: _____

Number of Children: _____

Children Names: _____

Notes About Children, Grandchildren, Family or Friends:

_____

_____

Education: _____

Previous Job/ Career Experience: _____

Other Organizations, Memberships, Affiliations:

_____

_____

_____

Hobbies or Interests:_____

_____

Favorite Activites:_____

_____

Food preferences:

| Likes: | Dislikes: |
|---|---|
| | |

Allergies?:_____

# DAILY ROUTINE

Morning Activites:_____

_____

Wake up at _____ Breakfast at _____

Daytime Activites:_____

_____

Lunch at _____ Break/Nap at _____

Afternoon Activities: _____

_____

Dinner at _____

Evening Activities: _____

_____

Bedtime at _____

## *Activities of Daily Living*

**Personal Care**

| | | |
|---|---|---|
| Bathing | Independent ☐ | Assisted ☐ |
| Dressing | Independent ☐ | Assisted ☐ |
| Grooming | Independent ☐ | Assisted ☐ |
| Eating | Independent ☐ | Assisted ☐ |
| Mobility (walking) | Independent ☐ | Assisted ☐ |
| Toileting | Independent ☐ | Assisted ☐ |
| Medication | Independent ☐ | Assisted ☐ |

**Household Care**

| | | |
|---|---|---|
| Driving / Transportation | Independent ☐ | Assisted ☐ |
| Grocery shopping | Independent ☐ | Assisted ☐ |
| Cooking | Independent ☐ | Assisted ☐ |
| Cleaning (light house work) | Independent ☐ | Assisted ☐ |
| Laundry | Independent ☐ | Assisted ☐ |