AgingCare.com

RESPITE CAREGIVER CHECKLIST

Patient Name _____

I will be away from _____to_____

Location_____ Phone _____

Diseases / ailments patient suffers from _____

_____

Symptoms _____

_____

_____

Allergies _____

DOCTORS, MEDICAL CARE AND EMERGENCY CONTACTS

Primary care doctor _____

Phone _____ Location _____

Specialist doctor _____

Phone _____ Location _____

Nearest hospital _____

Phone _____ Location _____

Medical Insurance _____

Friends and Relatives to contact in an emergency

Name/address_____ Phone_____

Name/address_____ Phone_____

MEDICATIONS

Medication Name	Dose	Time to give	Special Instructions

APPOINTMENTS

(doctor's office, physical therapy, beauty/barber, visit friends, activities, etc. Include date, time, location, contact name, phone number)

1. _____

2. _____

3. _____

ABOUT THE PATIENT

Patient's general emotional state (shy, weepy, sudden outbursts) _____

_____

Favorite distractions _____

Dislikes_____

Moving the patient (circle those that apply)

Moves around unassisted Needs assistance transferring from to chair

Requires lift/wheelchair/walker Bedbound

Special moving instructions _____

Physical Therapies/ Exercises Needed _____

_____

Toileting (circle those that apply)

Unassisted Catheter Colostomy

Bedside commode Bedpan Incontinent pads

Special instructions _____

Sleep

Bed time _____ Wake time _____ Nap _____

Meals (circle all that apply)

Eats unassisted Needs feeding assistance Needs to be fed

Has difficulty swallowing Eats soft foods only Tube feeding

Breakfast time _____ Lunch time _____

Dinner time _____ Snacks _____

Food allergies _____

Special eating instructions _____

_____

Entertainment

Patient enjoys (circle all that apply)

TV Radio Reading Being Read to Cards

Other _____

Avoid _____