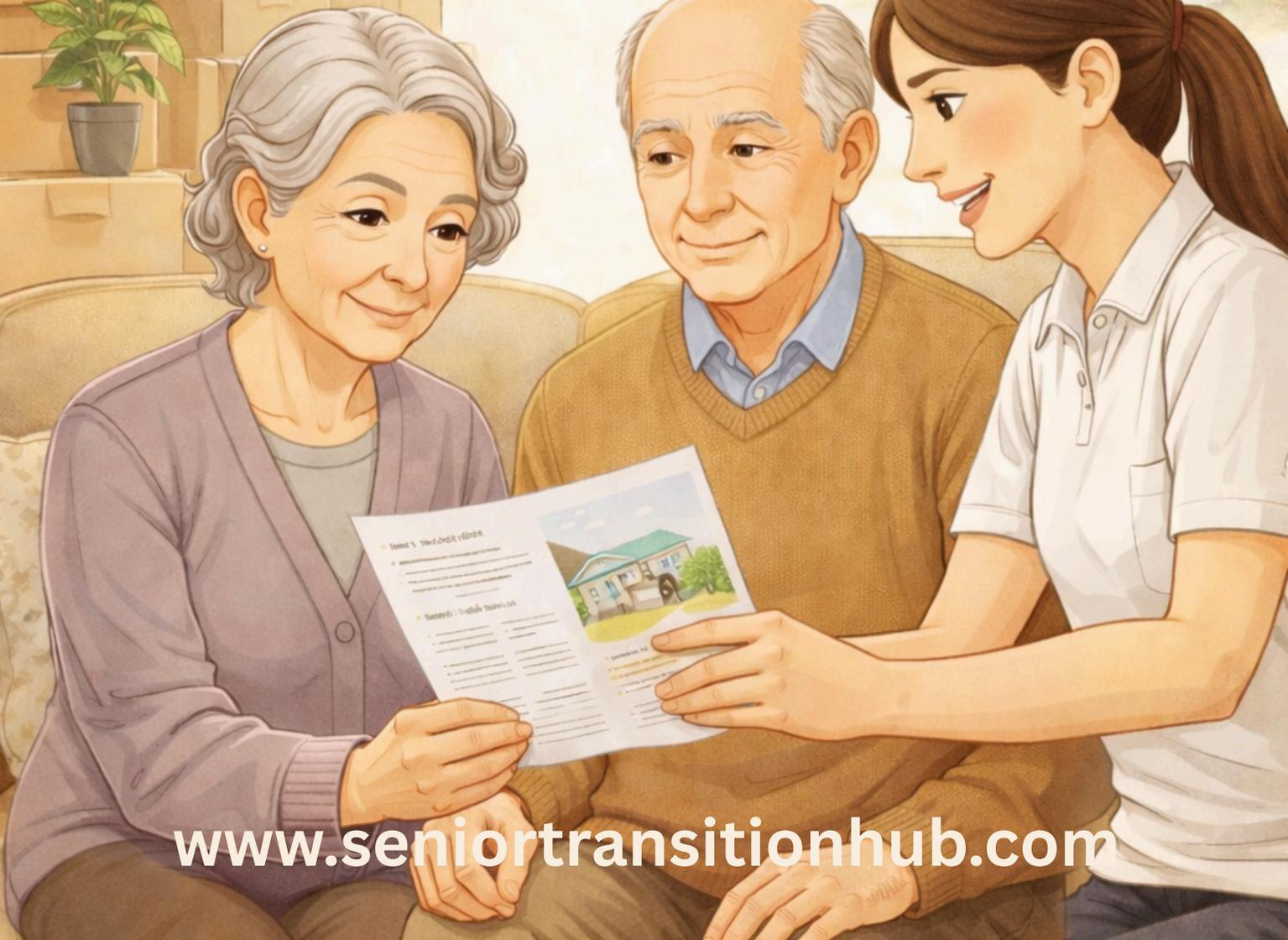


CAREGIVER GUIDE



 **Senior
Downsizing
Club™**
A Path to Simpler Living



www.seniortransitionhub.com

CARE RECIPIENT PROFILE

Basic Information
Name:
DOB:
Address:

Emergency Contact #1
Name:
Relationship:
Phone:

Emergency Contact #2
Name:
Relationship:
Phone:

Medical Info
Diagnoses:
Allergies:
Medical Equipment Used:

EMERGENCY PLAN

Steps To Take in an Emergency

--

Hospital Info

Preferred Hospital:
Address:
Code Status/DNR:
Power of Attorney:

Insurance Info

Provider:
Policy Holder:
Policy Number/Member ID:

MEDICAL HISTORY SUMMARY

Personal Information

Name:

DOB:

Diagnoses:

Health Overview

Mobility Needs: Independent Uses cane Uses walker Wheelchair

Hearing: Normal Hearing aid Hard of hearing

Vision: Normal Glasses Impaired

Cognition: Intact Mild memory loss Significant impairment

Speech: Normal Aphasia Nonverbal

Swallowing Issues: Yes No

Allergies: No Known Allergies Medication Allergies: _____

Food Allergies: _____ Environmental Allergies: _____

Surgeries/Hospitalizations

Providers

PROVIDER LIST

Specialty: _____
Name:
Phone:
Address:

Specialty: _____
Name:
Phone:
Address:

Specialty: _____
Name:
Phone:
Address:

THERAPIST INFORMATION

Discipline: _____
Name:
Phone:

Discipline: _____
Name:
Address:

Discipline: _____
Name:
Phone:

Discipline: _____
Name:
Phone:

MEAL & BEVERAGE PREFERENCES

Preferences

Meals and Snacks:

Beverages:

Meal Times:

Dislikes, Allergies, Special Diet

Foods to Avoid:

Allergies:

Special Diet:

Tools/Equipment Used:

CARE RECIPIENT PREFERENCES

Favorites

Movies/Shows:

Music:

Books/Authors:

Hobbies:

Games:

Animals/Pets:

Colors:

Scents:

Comfort Items:

Social/Community:

ROUTINE PREFERENCES

	Preferred Activities/Notes
Morning	
Afternoon	
Evening	
Bedtime	

CAREGIVER SIGN IN & SIGN OUT

Date	Name	Time In	Time Out	Total Hours

CAREGIVER REIMBURSEMENT LOG

Date	Purchase	Amount Paid	Receipt	Notes
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
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			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

RESOURCE & SUPPORT DIRECTORY

Name of Resource	Contact	Notes

REPOSITIONING LOG

Date	Time	Position	Skin Check	Notes
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
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			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

MEDICATION LOG

Medication/Dose	Time	Checklist
		S M T W T F S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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		S M T W T F S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

BATHROOM LOG

Date	Time	Type	Accident	Notes
		<input type="checkbox"/> Bowel <input type="checkbox"/> Bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Bowel <input type="checkbox"/> Bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Bowel <input type="checkbox"/> Bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Bowel <input type="checkbox"/> Bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Bowel <input type="checkbox"/> Bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Bowel <input type="checkbox"/> Bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Bowel <input type="checkbox"/> Bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Bowel <input type="checkbox"/> Bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Bowel <input type="checkbox"/> Bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Bowel <input type="checkbox"/> Bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Bowel <input type="checkbox"/> Bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Bowel <input type="checkbox"/> Bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Bowel <input type="checkbox"/> Bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Bowel <input type="checkbox"/> Bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No	

WEEKLY ACTIVITY TRACKER

	Mon	Tues	Wed	Thurs	Fri	Weekend
Physical						
Creative						
Cognitive						
Social						

THERAPY HOMEWORK TRACKER

Discipline	Activity	Instructions	Frequency	Tracking
				S M T W T F S ○ ○ ○ ○ ○ ○ ○
				S M T W T F S ○ ○ ○ ○ ○ ○ ○
				S M T W T F S ○ ○ ○ ○ ○ ○ ○
				S M T W T F S ○ ○ ○ ○ ○ ○ ○

MONTH OVERVIEW

Sun	Mon	Tues	Wed	Thurs	Fri	Sat

WEEK OVERVIEW

Mon	
Tue	
Wed	
Thu	
Fri	
Sat	
Sun	

DAILY SCHEDULE

7:00am	
8:00am	
9:00am	
10:00am	
11:00am	
12:00pm	
1:00pm	
2:00pm	
3:00pm	
4:00pm	
5:00pm	
6:00pm	
7:00pm	
8:00pm	
9:00pm	
10:00pm	

WEEKLY MEAL PLANNER

	Breakfast	Lunch	Dinner	Snacks
Mon				
Tue				
Wed				
Thu				
Fri				
Sat				
Sun				

DAILY SELF CARE CHECKLIST

	AM	Mid Day	PM	Notes
Bathing/Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oral Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating/Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Positioning/Pressure Relief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fluids/Hydration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

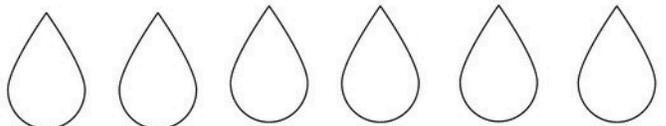
Notes:

EMOTIONAL WELLNESS SUMMARY

Observed Mood	Triggers/Patterns
<input type="checkbox"/> Content <input type="checkbox"/> Withdrawn <input type="checkbox"/> Anxious <input type="checkbox"/> Agitated <input type="checkbox"/> Happy <input type="checkbox"/> Confused <input type="checkbox"/> Tired <input type="checkbox"/> Restless <input type="checkbox"/> Irritable <input type="checkbox"/> Calm <input type="checkbox"/> Sad <input type="checkbox"/> Energetic	
Observed Behaviors	Positive Moments
1. _____ 2. _____ 3. _____ 4. _____ 5. _____	
Mood Rating	Activities
	1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Notes:

DAY SUMMARY

Vitals	Appointments/Therapy
Temperature: _____ °F Blood Pressure: _____ / _____ mmHg Pulse: _____ bpm Respirations: _____ per min Oxygen Saturation: _____ %	Time: _____ Notes: _____ Time: _____ Notes: _____
Mood	Meals
	<input type="checkbox"/> Breakfast: _____ <input type="checkbox"/> Lunch: _____ <input type="checkbox"/> Dinner: _____
Pain	Fluid/Hydration
Location: _____ 1 2 3 4 5 6 7 8 9 10 	
Fatigue	Self Care
	<input type="checkbox"/> Dressing <input type="checkbox"/> Oral Care <input type="checkbox"/> Bathing <input type="checkbox"/> Toileting <input type="checkbox"/> Grooming <input type="checkbox"/> Positioning
Medications	Activities
<input type="checkbox"/> All Taken as Prescribed <input type="checkbox"/> Missed Medications: _____ _____	

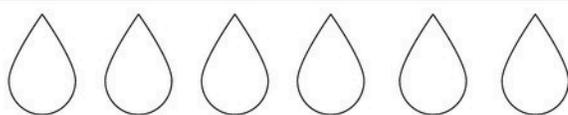
FATIGUE TRACKING

Activity	Fatigue Level Before (1-10)	Fatigue Level After (1-10)	Notes

Sleep

1 2 3 4 5 6 7 8 9 10

Hydration



Mood



Meal	Time

Notes

Breaks

SYMPTOM TRACKING

Symptom	Intensity 1-10	Duration	Notes

Time	Activity

Mood

Hydration

Meal	Time

Sleep

APPOINTMENT NOTES

Date	
Time	
Provider	
Purpose of Visit	
Visit Notes	
Recommendations	
Next Visit	

THERAPY NOTES

Date	
Therapist	
Discipline	
Focus of Session	
Activities	
Progress & Observations	
Recommendations	
Next Visit	

GROCERY LIST

Produce	Protein & Dairy	Grains/Pantry

Frozen	Snacks & Drinks	Household & Personal

CLEANING LOG

Living Room	Entryways/Hallways	Other
<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>

Kitchen	Bathroom	Bedroom
<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>
<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/> <input type="text"/>

MONTHLY CARE EXPENSE TOTALS

Mobility/Medical Equipment	Medications/Prescriptions	Healthcare Services

Incontinence Supplies	Personal Care Items	Transportation/Gas

Groceries/Food	House and Cleaning Supplies	Hired Help/Caregivers

Other