Substitute Caregiver/Respite
Member Information Sheet

Date Completed:_____

By:_____

To assist the Substitute Caregiver in providing the best care for the Member, please answer the following questions related to the Member's care needs. If the question does not pertain to the Member please put n/a. Please give copies to each of your Substitute Caregivers.

IDENTIFYING INFORMATION

Name:_____ DOB:_____

Primary Caregiver/AFH Caregiver:_____

Address:_____ Phone:_____

Guardian:_____ Phone:_____

Social Worker, which agency:_____ Phone:_____

Nurse:_____ Phone:_____

Family Contacts - List Relationship, Location and Phone

1:_____

2:_____

EMERGENY CONTACT– List Relationship, Location and Phone **Other than above**

1:_____

2:_____

3:_____

TRANSPORTATION

Transportation Vendor:_____ Phone:_____

Who will transport Member to substitute care home?_____

Who will transport Member back to the Member's home?_____

MEDICAL INFORMATION

Primary Doctor:_____ Phone:_____

Location:_____

Other Doctors or Service Caregiver:_____

_____

Dentist:_____Phone:_____
Pharmacy:_____Phone:_____
Location:_____

1. List any Medical diagnosis._____
2. List any Mental Health diagnosis._____
3. Describe any special monitoring, activity restrictions the Member needs due to their health.__
4. Any allergies? ___Yes___No List_____
5. Member needs assistance with understanding basic conversation? ___Yes___No
   If Yes Due to (circle): Hearing Cognition Confusion Other:_____
6. History of or currently any seizures? ___Yes___No
7. Member has regular medication that needs to be administered daily? ___Yes___No
   If yes please list all regular medications, the dose and time given._____
8. Other:_____

ASSISTIVE DEVICES

1. Does Member have dentures? ___No___Upper___Lower___Both___Partial
2. Does Member wear eye glasses? ___Yes___No
3. Does Member wear hearing aids ___No___Left___Right___Both
4. Does Member use a walker, cane, wheelchair etc to move around? ___Yes___No
   Describe:_____
5. Other:_____

SUPERVISION NEEDS

1. Member needs 24 hour supervision? ___Yes___No
2. Member needs eyes on supervision (Member is never out of caregiver's sight) inside the home? ___Yes___No
3. Member needs eyes on supervision outside of the home (yard, community, store, etc)? ___Yes___No

4. Member has a history of elopement? ___Yes___No

PERSONAL CARE NEEDS

1. Member needs how much assistance with the following. Please check the box that applies and describe (ex. Hair Care – check verbal reminders "to brush", check total care "needs help washing and rinsing in shower"

	No Assistance	Verbal Remind	Hands on Assistance	Total Care
Bathing				
Toileting				
Shaving				
Nail care				
Hair care				
Oral care				
Dressing				
Menstrual Care				

2. Member is incontinent? ___Yes___No
   List any incontinence products the Member uses?_____
3. Does the Member regularly get up to use the bathroom at night? ___Yes___No

BEHAVIORAL INFORMATION

1. Does the member exhibit any challenging behaviors? ___Yes___No if yes please list
2. Is it important for the Member to have a consistent routine? ___Yes___No
3. Any alcohol or drug issues? ___Yes___No Describe_____
   _____
4. Member needs verbal redirection? ___Yes___No Frequency_____
5. Member needs positive feedback? ___Yes___No Frequency_____

6. Caregiver should ignore undesired behavior? ___Yes___No Frequency/Describe_____
   _____
7. Caregiver should give redirection as needed? ___Yes___No Frequency/Describe_____
   _____
8. Caregiver should identify triggers (foreshadow) to assist Member with controlling behavior? ___Yes___No Frequency/Describe_____
   _____
9. Member is physically aggressive? ___Yes___No Frequency/Describe_____
   _____
10. Member is verbally aggressive? ___Yes___No Frequency/Describe_____
    _____
11. Any self harm behaviors? ___Yes___No Describe_____
    _____
12. Member has sexual behaviors? ___Yes___No Frequency/Describe_____
    _____
13. Member has destroyed property? ___Yes___No Frequency/Describe_____
    _____
14. Other:_____

FOOD

1. Is the Member on a special diet? ___Yes___No Describe_____
   _____
2. Is the Member at risk for choking? ___Yes___No
3. Any food allergies? ___Yes___No List_____
4. The caregiver must always supervise when Member eats? ___Yes___No
5. How should food be served? (cut up, pureed, assist w/feeding)_____
   _____
6. Food/Restaurants/Meals Member Likes_____
   _____
7. Food Member Dislikes_____
   _____

DAILY ROUTINE

1. What time does the Member typically wake up?_____
2. What time does the Member typically go to bed?_____
3. What does a typical week/weekend day look like for the Member? What kind of activities do they like to do? Any set routines?_____
   _____

ACTIVITIES / SKILLS

1. Is the Member currently working on improving any skills? ___Yes___No List. How can the caregiver assist?_____
2. Does the Member need assistance with managing their money? ___Yes___No
3. Member's Favorite:
    a. Place in the community_____
    b. Place to eat out_____
    c. Activity_____
    d. Color_____
    e. Game_____
    f. TV Show/Movie_____
    g. Music_____
    h. Subject to talk about_____
4. What is important to the Member?_____
5. Activities the Member does <u>not</u> like?_____
6. Is spirituality or religion important to Member? ___Yes___No Describe._____

OTHER

Is there any information about the Member that you feel would be important for a Substitute Care Caregiver to know?_____