IMPORTANT INFORMATION ABOUT MY LOVED ONE

Caregiver Connection of Ozaukee County

Loved One's Name:_____

Address:_____

_____

Date of Birth: _____

Primary Doctor's Name:_____

Type of Doctor: _____

Phone #:_____

Clinic Name:_____

Medical insurance information and cards located:_____

Health Care Proxy located:_____

Living Will on file at:_____

In case of an emergency, do the following (Check one):

_____Call 911

OR

_____Call this number for transport to hospital:

Transport Company's name:_____

Phone #:_____

___they have a DNR order and DNR bracelet on them

FIRST TO CALL:

Name:_____

Relationship:_____

Cell #:_____ Home #:_____ Work #:_____

SECOND TO CALL:

Name:_____

Relationship:_____

Cell #:_____ Home #:_____ Work #:_____

Take the medication sheet and following items with you to the Hospital:

All Medications are located:_____

Do they wear Dentures? ___Yes ___No

Do they wear Glasses/Contacts? ___Yes ___No

Their medical condition/diagnosis:_____

Year diagnosed:_____

Allergies:_____

Other information (example: pacemaker, recent tests…)_____

Communication: (Check one) is he/she:

___verbal ___non-verbal ___needs help finding words

Preferred hospital:_____

Loved one's schedule:

Eating Routine:

Include foods he/she likes, times to eat meals, hydration and any other suggestions:

Living Routine:

Include sleep time schedules, what he/she enjoys doing, how to comfort and any other suggestions:

Personal Care:

Include dressing, grooming, bathing, toileting and any other habits:

Equipment & Assistance:

Include assistance needed for transfers, waking and equipment that is used:

Other Comments:

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of Ozaukee County

DAILY MEDICATION

Include all prescription and non-prescription (herbals, over-the-counter, vitamins)

NAME OF MEDICATION	REASON	PILL COLOR	DOSAGE	TIME TAKEN	WITH OR WITHOUT FOOD