

RESPIRE CAREGIVER CHECKLIST

Respite care is when someone comes and gives the regular caregiver some "time off" from their duties, but that does not mean that the respite care caregiver has complete knowledge of the person requiring care. This checklist was used by EIM staff person Karen Bragg when she cared for her Grandmother at home, but you can print out and make your own revisions. "It saved me a lot of time, questions and anxiety."

Name: _____

Address Here (In case of needing ambulance)

Birth date _____

Doctor _____ Phone _____ Location _____

Hospital _____ Phone _____ Medical Insurance _____

Home/ Health/Hospice Patient? _____ Agency Phone _____ Nurse _____

Diagnoses _____ How Long _____

Characteristics of diagnoses affecting care _____

Current Symptoms _____

Allergies _____ History of seizures?? _____

General emotional state (shy, sense of humor, weepy, sudden outbursts, etc) _____

_____ Generally understand instructions

_____ May not understand instructions

_____ Vision Limitations

Favorites /Likes _____

Dislikes

Distractions that usually help: _____

Gloves can be found _____

MEDICATION REMINDERS	Medication Location		
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1. : _____

2. _____

3. _____

Medical Equipment	When	Needs Assistance	Need to Know
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1. _____

2. _____

Appointments (doctor's office, physical therapy, beauty/barber, visit friends, ball game, etc.)

To (Name)	Location	phone	Date	Time
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1. _____

2. _____

PERSONAL CARE AND COMFORT

Circle and if needed, (attach instructions to this sheet)

Dentures	Assist with toileting	Assist with dressing		Assist with Grooming
Eye Glasses	Assist with Bathing	Assist with Mouth Care		Wears Make-up

Moving - Circle

Moves around unassisted	Transfers from bed to chair with assistance	Bed bound	Reposition	Requires Special lift
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Special Instructions

Walking-

Transporting in car-

Unassisted	Cane	Walker	Wheelchair
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4. Special Exercises _____

Toileting

Unassisted	Bedpan	Urinal	Catheter	Colostomy
Bedside Commode	Incontinent pads	other		

Bathing

Bed bath	Shower	Tub	Needs assistance	__ times per week
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Equipment needed

1. None
2. Transfer bench
3. Shower bench
4. Wheelchair

Bedroom Comfort

Bedtime	Wake time	Nap time(s)	Room temperature	Closed windows
Prefers room dark				

Change Bed

Pull sheet	Blankets(s)	Day__ or night__
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Special bed items (sheepskin, egg crate mattress, extra pillows- attach sheet)

Food- for meals/snacks or special instructions, see attached list

Needs Assistance feeding	Needs to be fed	Has difficulty swallowing	Takes nothing by mouth
Soft foods Only	Record Liquid Intake		

Meal times__ Breakfast__ Lunch__ Dinner__ Snack

Entertainment Options/preferences

TV	Radio	Reading or being read to	games	Other
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Avoid _____

Other enjoyable activities: _____

Family photo album located: _____

Enjoys talking about: _____

Some history: _____

HOUSE RULES AND INSTRUCTIONS

1. Locking Doors -
2. Smoking-
3. Working Stove-
4. Fireplace -
5. Gas shut off valve-
6. Fire Extinguishers -
7. Guests-
8. Pets-
9. Neighbors-
10. Utility company numbers located:

Other information _____

EMERGENCY PREPAREDNESS

Discuss 911 preferences _____

DNR Order or Advanced Directives can be found _____

I'll return home on _____

I will be away from _____ to _____

Location _____ Phone _____ Cell _____

Friends and Relatives you can contact in an emergency

Name/address _____ Phone _____

Cell _____

Name/address _____ Phone _____

Cell _____