**RESPITE VOLUNTEERS OF SHIAWASSEE**

**PATIENT, FAMILY & HOME SAFETY ASSESSMENT & CARE PLAN**

Assessment Date: Intake Date:

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_

**E-Mail:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Home: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip: County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Township:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex\_\_\_\_\_ Race\_\_\_\_\_ Smoking: Pt.\_\_\_\_\_\_ In home\_\_\_\_\_\_\_ Pets: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vet\_\_\_\_\_\_ Spouse a Vet Previous Occupation(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Living Arrangements – Whose home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Own or Rent (circle) Number living in home:\_\_\_\_\_\_\_

Education:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Church, City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Environment/Accessibility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Daily Routine:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hobbies/Interest:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Caregiver # 1** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-Mail:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (If Different):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**D.O.B.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_

Phone: Home ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell( )\_\_\_\_\_\_\_\_\_\_\_\_\_

Role/Responsibilities\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Caregiver # 3**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-Mail:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (If Different):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**D.O.B.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_

Phone: Home ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell( )\_\_\_\_\_\_\_\_\_\_\_\_\_

Role/Responsibilities\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Caregiver # 2**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-Mail:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (If Different):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**D.O.B.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_

Phone: Home ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell( )\_\_\_\_\_\_\_\_\_\_\_\_\_

Role/Responsibilities\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Caregiver # 4**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-Mail:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (If Different):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**D.O.B.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_

Phone: Home ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell( )\_\_\_\_\_\_\_\_\_\_\_\_\_

Role/Responsibilities\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Is on Disability**\_\_\_\_\_\_\_\_\_\_ - recognized by Social Security &/or VA (circle) In Process\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Health Conditions:**

1. Accident
2. Amputee
3. Arthritis
4. Auto immune/Aids
5. Cancer
6. Cerebral Palsy
7. Dementia/Alzheimer’s
8. Diabetes Insulin\_\_\_\_\_
9. Emotionally Disabled/Grief
10. Epilepsy
11. Fractures
12. Heart Disease
13. Hypertension
14. Intellectual/Learning Disability
15. Lung Disease
16. Neurological
17. Mental Health\_\_\_\_\_\_\_\_\_\_\_\_
18. Muscular Dystrophy
19. Multiple Sclerosis
20. Osteoporosis
21. Paralysis
22. Parkinson’s Disease
23. Renal(Kidney)Failure
24. Sundowner’s Syndrome
25. Ulcers
26. CVA (Stroke

**Mental Health: treatment, medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other** (hospitalizations, falls, surgeries) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Ask for persons with Dementia (Including Alzheimer’s), mentally impaired and emotionally disabled:**

Short-Term Memory Loss\_\_\_\_\_\_\_\_\_\_\_Confusion\_\_\_\_\_\_\_\_\_\_\_Disorientation\_\_\_\_\_\_\_\_\_\_\_Agitation\_\_\_\_\_\_\_\_\_\_\_

Depression \_\_\_\_\_\_\_\_\_\_\_Wanders \_\_\_\_\_\_\_\_\_\_\_Other (explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities, approaches are calming \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications Presently Used (Not to be administered by volunteer)**

Medication & Reason Prescribed: Medication & Reason Prescribed:

**Are medications kept safely secure?** \_\_\_\_\_\_\_\_\_\_**Where are they stored?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there use of medical marijuana? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies (food & environmental): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACTIVITIES OF DAILY LIVING** (write explanation of help needed)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **SENSORY**  **ACTIVITY** | **Excellent** | **Fair** | **Poor** | **FUNCTIONAL**  **ACTIVITY** | **Independent** | **Needs**  **Assistance** | **Unable**  **to do** |
| **Vision** |  |  |  | **Mobility** |  |  |  |
| **Hearing** |  |  |  | **Transferring** |  |  |  |
| **Verbal**  **Instructions** |  |  |  | **Eating/**  **Dentures** |  |  |  |
| **Written**  **Instructions** |  |  |  | **Toileting** |  |  |  |

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**Medical Equipment in the Home:**

 Commode  Wheelchair  Raised Toilet Seat  Widened Doorways

 Walker/type\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Oxygen/type\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Bathroom Safety Bars  Ramp

 Other  Stairway Railings  Shower Chair  Hospital Bed

**Respite recommendations:**

**Handicapped Accessible Remodeling needed:**

**Service(s) Receiving:**

Private Duty Personal Care Meals on Wheels ( agency)

Homemaker/Chore Services Care Management Home Health

Medicaid Waiver Hospice

**Fill in Name**

Preferred Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Physician Specialist (1)

(2) \_\_\_\_\_\_\_\_\_\_\_\_\_ (3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(4)­­­­­ ­­­­ ­­­­­ Private Duty Agency

Home Health Agency Telephone

Home Health Nurse Home Health Social Worker \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Housekeeper \_\_\_\_\_( Private Duty or  Agency) \_\_

Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Medicaid \*Medicare \*Waiver \*Applying

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Refer to SATA, Transportation Solutions for requests

**Needs of the Patient (2-4 Hours) of:**

Social Time (Talk, T.V., Cards, Etc)

Special Care/Watch - Feed, Bathroom, Transfer & type of Transfer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other:

**Times/Days Preferred:**

Mornings\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Afternoons\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evenings\_\_\_\_\_\_\_\_\_\_\_\_ M TU W TH F SA SU

**Special Request:**

**Needs of the Caregiver (2-4 Hours) of**:

 Run Errands  Go to Commitments (Meetings, Clubs, Group Socials)

Go out with Friends/Family  Personal Appointment (Doctors, Dentist, Hair, Nails)

 Time to Do Household Chores  Other

**Present Caregiver(s):**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep: How many hours per day?**  **Is this adequate?**

**Caregiver’s health?**

**Caregiver’s “Other” responsibilities:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Funding & Grant Writing Purposes Only**

**1st Monthly Income & Source\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2nd Monthly Income & Source\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3rd Monthly Income & Source\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Income: Yearly\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Are there firearms on the property?** **Yes**  **No. If yes, are they locked up securely?**  **Yes**  **No**

 **Gun Cabinet /w Lock or**  **Gun Locks or**  **both? If NO then need a plan:**

**Contact Persons: (i.e. Neighbor close by)**

**1. Name** Relationship

Address City Zip -

Phone: Home ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Name** Relationship

Address City Zip -

Phone: Home ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Children:**

Name Address City Phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Names of Adult Grand Children in the area:**

**Names of Adult Great-Grand Children in the area:**

**Emergency Procedures*:* For Medical Emergency the Volunteer is instructed to CALL 911**

**Do Not Resuscitate Order:**  **Yes**  **No, Need education:\_\_\_\_\_Do Not Resuscitate Bracelet:**  **Yes**  **No**

**Location of document:**

Medical Durable Power of Attorney (MDPA) paperwork has been done? Yes  No - Activated? Yes  No

Who is MDPA Financial?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who is MDPA Medical?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that this information will be given to the Respite Care Volunteer and a copy will be kept in the Respite Volunteers of Shiawassee office. This information is strictly confidential and will not be released to any person without my permission. I hereby give permission to the Respite Volunteer, to secure emergency medical and/or emergency surgical treatment for the above named client.

Person to Receive Services Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Caregiver Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Family Present \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coordinator Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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