

# Caregiver Emergency Readiness Guide

**Kerr-Tar**  
Area Agency on Aging

# Photo Identification

Complete this form in **pencil** and update document frequently.

Care Recipient Name/Older Adults Name: \_\_\_\_\_

Place current photo here

Caregiver Name/Older Adults Name: \_\_\_\_\_

Place current photo here

# Emergency Readiness Information

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## Individuals Information

Name of care recipient: \_\_\_\_\_ Age: \_\_\_\_\_

Nick Names: \_\_\_\_\_

Primary Address: \_\_\_\_\_

Primary Caregiver: \_\_\_\_\_ Relationship: \_\_\_\_\_

Caregivers Address: \_\_\_\_\_

Caregivers Home phone: \_\_\_\_\_ Cell: \_\_\_\_\_

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## Emergency Contact/Caregiver:

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

Address: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Hours of Care: \_\_\_\_\_

## Alternate Contact/Caregivers:

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Hours of Care: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Hours of Care: \_\_\_\_\_

## Others willing to assist and nearest relatives to notify:

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: Home: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: Home: \_\_\_\_\_

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**Advance Directives**

**Does the individual have a living will?**                      **Yes**                      **NO**

**Location of original documents:** \_\_\_\_\_

*Filed with:* \_\_\_\_\_

*Address:* \_\_\_\_\_

*Phone(s): (home):* \_\_\_\_\_ *(Cell):* \_\_\_\_\_

**Individuals Code Status:** *Full Code*                      *DNR (Do Not Resuscitate)* **Location of Original Document:** \_\_\_\_\_

**Healthcare Surrogate or Power of Attorney for Health Care:**                      **Yes**                      **No**

**Location of original documents:** \_\_\_\_\_

1. *Contact:* \_\_\_\_\_ *Relationship:* \_\_\_\_\_

*Address:* \_\_\_\_\_

*Phone:* \_\_\_\_\_ *Cell:* \_\_\_\_\_

2. *Contact:* \_\_\_\_\_ *Relationship:* \_\_\_\_\_

*Address:* \_\_\_\_\_

*Phone:* \_\_\_\_\_ *Cell:* \_\_\_\_\_

3. *Contact:* \_\_\_\_\_ *Relationship:* \_\_\_\_\_

*Address:* \_\_\_\_\_

*Phone:* \_\_\_\_\_ *Cell:* \_\_\_\_\_

**Financial surrogate or Power of Attorney for financial affairs:**                      **Yes**                      **No**

**Location of Original Documents:** \_\_\_\_\_

1. *Contact:* \_\_\_\_\_ *Relationship:* \_\_\_\_\_

*Address:* \_\_\_\_\_

*Phone:* \_\_\_\_\_ *Cell:* \_\_\_\_\_

2. *Contact:* \_\_\_\_\_ *Relationship:* \_\_\_\_\_

*Address:* \_\_\_\_\_

*Phone:* \_\_\_\_\_ *Cell:* \_\_\_\_\_

3. *Contact:* \_\_\_\_\_ *Relationship:* \_\_\_\_\_

*Address:* \_\_\_\_\_

*Phone:* \_\_\_\_\_ *Cell:* \_\_\_\_\_

**General or Special Power of Attorney**                      **Yes**                      **No**

**Location of original documents:** \_\_\_\_\_

1. *Contact:* \_\_\_\_\_ *Relationship:* \_\_\_\_\_

*Address:* \_\_\_\_\_

*Phone:* \_\_\_\_\_ *Cell:* \_\_\_\_\_

**Healthcare and Services**

The person with dementia/Alzheimer is currently receiving services from the following agency/agencies

1. **Agency:** \_\_\_\_\_  
**Contact:** \_\_\_\_\_  
**Services receiving:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_ **City:** \_\_\_\_\_  
**Notes:** \_\_\_\_\_
  
2. **Agency:** \_\_\_\_\_  
**Contact:** \_\_\_\_\_  
**Services receiving:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_ **City:** \_\_\_\_\_  
**Notes:** \_\_\_\_\_
  
3. **Agency:** \_\_\_\_\_  
**Contact:** \_\_\_\_\_  
**Services receiving:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_ **City:** \_\_\_\_\_  
**Notes:** \_\_\_\_\_

**Medical Equipment Needs:**

<i>Communicates by:</i>	<i>Speaking</i> ( )	<i>Gesture</i> ( )	<i>Pictures</i> ( )
<i>Catheter</i> ( )	<i>Wheelchair</i> ( )	<i>Hearing Aid R</i> ( )	<i>Hearing Aid L</i> ( )
<i>Colostomy</i> ( )	<i>Prosthesis</i> ( )	<i>Cane</i> ( )	<i>Walker</i> ( )
<i>Crutch's</i> ( )	<i>Can Speak</i> ( )	<i>Can Write</i> ( )	_____ ( )
_____ ( )	_____ ( )	_____ ( )	_____ ( )

<b><u>Vision</u></b>	<b><u>R</u></b>	<b><u>L</u></b>	<b><u>Comment:</u></b>	<b><u>Hearing</u></b>	<b><u>R</u></b>	<b><u>L</u></b>	<b><u>Comment:</u></b>
Good	( )	( )	_____	Good	( )	( )	_____
Limited	( )	( )	_____	Limited	( )	( )	_____
Blind	( )	( )	_____	Blind	( )	( )	_____
Glasses	( )	( )	_____	Deaf	( )	( )	_____
Contacts	( )	( )	_____	Aides	( )	( )	_____
Other: _____	( )	( )	_____	Other: _____	( )	( )	_____

Medical

**Primary Care Physician:** \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

<b>Medical Conditions</b>	<b>Y</b>	<b>N</b>	<b>Physician</b>	<b>Phone:</b>
<i>Alzheimer's disease</i>	( )	( )	_____	_____
<i>Alcoholism</i>	( )	( )	_____	_____
<i>Amputation</i>	( )	( )	_____	_____
<i>Arthritis</i>	( )	( )	_____	_____
<i>Asthma</i>	( )	( )	_____	_____
<i>COPD</i>	( )	( )	_____	_____
<i>Cancer</i>	( )	( )	_____	_____
<i>Colitis</i>	( )	( )	_____	_____
<i>Dentures/Partials</i>	( )	( )	_____	_____
<i>Diabetes (Type_____)</i>	( )	( )	_____	_____
<i>Epilepsy/Seizures</i>	( )	( )	_____	_____
<i>Glaucoma</i>	( )	( )	_____	_____
<i>Heart disease</i>	( )	( )	_____	_____
<i>Hepatitis</i>	( )	( )	_____	_____
<i>High blood pressure</i>	( )	( )	_____	_____
<i>Low blood pressure</i>	( )	( )	_____	_____
<i>Multiple sclerosis</i>	( )	( )	_____	_____
<i>Pace maker</i>	( )	( )	_____	_____
<i>Parkinson 's disease</i>	( )	( )	_____	_____
<i>Prostate</i>	( )	( )	_____	_____
<i>Skeletal trauma</i>	( )	( )	_____	_____
<i>Thyroid</i>	( )	( )	_____	_____
<i>Tuberculosis</i>	( )	( )	_____	_____
<i>Ulcer</i>	( )	( )	_____	_____
<i>Other:</i>				
<i>Specify: _____</i>	( )	( )	_____	_____
<i>Specify: _____</i>	( )	( )	_____	_____

Surgeries:

1. Type of surgery: \_\_\_\_\_ Date: \_\_\_\_\_
2. Type of surgery: \_\_\_\_\_ Date: \_\_\_\_\_
3. Type of surgery: \_\_\_\_\_ Date: \_\_\_\_\_
4. Type of surgery: \_\_\_\_\_ Date: \_\_\_\_\_
5. Type of surgery: \_\_\_\_\_ Date: \_\_\_\_\_

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### Nutritional Status

Does the care recipient have a diet prescribed by a physician? YES ( ) No ( )

If yes, describe: \_\_\_\_\_

List of food allergies: \_\_\_\_\_

Does he/she normally have a good appetite? YES ( ) NO ( )

Favorite Foods: \_\_\_\_\_

Least favorite foods: \_\_\_\_\_

Mealtimes:

Breakfast: \_\_\_\_\_ Lunch: \_\_\_\_\_ Dinner: \_\_\_\_\_ Snack: \_\_\_\_\_

Additional comments: \_\_\_\_\_

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### Functional Status Summary

Primary language: \_\_\_\_\_ other known Languages: \_\_\_\_\_

**Specify what type of assistance is needed with the following:**

	<b>Yes</b>	<b>No</b>	<b>Comments:</b>
Prepare meals	( )	( )	_____
Shop for personal items	( )	( )	_____
Manage own medications	( )	( )	_____
Manages own money	( )	( )	_____
Uses telephone independently	( )	( )	_____
Can do heavy housework	( )	( )	_____
Can do light housework	( )	( )	_____
Able to drive	( )	( )	_____
Eats independently	( )	( )	_____
Dresses independently	( )	( )	_____
Baths self independently	( )	( )	_____
Oral care independently	( )	( )	_____
Toilets independently	( )	( )	_____
Transfers into/out of bed/chair	( )	( )	_____
Ambulates independently	( )	( )	_____

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**Identification**

Does the care recipient with dementia or other health concerns wear an ID bracelet or GPS type locator? YES ( ) NO ( )

If yes, type and ID information: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Is the care recipient on the Special needs registration: YES ( ) NO ( )

If yes, what information has been given to the registry: \_\_\_\_\_

\_\_\_\_\_

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**Intellectual Functioning & Behaviors:**

Reacts to own name:	Almost always ( )	Sometimes ( )	Never ( )
Knows caregiver:	Almost always ( )	Sometimes ( )	Never ( )
Knows location:	Almost always ( )	Sometimes ( )	Never ( )
Short term memory loss:	Almost always ( )	Sometime ( )	Never ( )
Long term memory loss	Almost always ( )	Sometime ( )	Never ( )
Sleep habits:	Sleeps most or all nights ( )	Sometimes wakes ( )	often wakes ( )

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**Insurance Information:**

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Medicare Effective Date: \_\_\_\_\_

Insurance cards are located: \_\_\_\_\_

Secondary insurance (company/member i.d): \_\_\_\_\_

Medicare Part D (Pharmacy Insurance): \_\_\_\_\_

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**Primary Pharmacy:**

Company name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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**Exhibited Behaviors:**

**Check appropriate answers regarding behaviors:**

<i>Wanders-without purpose or regard for safety</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Pacing without purpose or regards to surroundings</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Has sundowners Behaviors (up throughout the evening time)</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Verbally threatens others:</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Physically tries to harm others</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Exposes him/herself in public</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Hallucinates/Delusions</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Exhibits quick mood shifts</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Depression</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Cries without cause</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Destroys things or is destructive</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Picking at self or at objects consistently</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Repetitive verbalization</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Refusal of care</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Misinterpretation of information</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Compulsive eating</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Suspicious or accusing behavior towards others</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Obsessive behaviors</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Abusive, self-berates or injures self</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Has increased anxiety at times</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Rummaging behaviors</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Dose not like to be touched by others</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Continually seeking touch by others</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Has sexual oriented inappropriate behaviors</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>
<i>Hoarders or steals small items</i>	<i>Never ( )</i>	<i>Sometimes ( )</i>	<i>Often ( )</i>

Items of Interest: \_\_\_\_\_

Other behaviors: \_\_\_\_\_ *Never ( )* *Sometimes ( )* *Often ( )*

Other behaviors: \_\_\_\_\_ *Never ( )* *Sometimes ( )* *Often ( )*

## Activities

**Check, what best describes the care recipient's participation in the following activities:**

1. Reads the newspaper, books or magazines YES ( ) NO ( )

2. Watches TV: YES ( ) NO ( )

*Favorite shows:* \_\_\_\_\_

3. Listens radio or music: YES ( ) NO ( )

*Favorite type of music:* \_\_\_\_\_

4. Works on a hobby: YES ( ) NO ( )

*Type of hobbies of interest:* \_\_\_\_\_

*Comment:* \_\_\_\_\_

5. Attends Church (Religion: \_\_\_\_\_) YES ( ) NO ( )

*Comment:* \_\_\_\_\_

6. Enjoys naps (Time of day: \_\_\_\_\_) YES ( ) NO ( )

*Comment:* \_\_\_\_\_

7. Attends adult day care

*Place and frequency/days per week:* \_\_\_\_\_

*Name and phone number of facility:* \_\_\_\_\_

8. Senior Companion

*Name:* \_\_\_\_\_

*Hours/days of week of service:* \_\_\_\_\_

*Daily routine/habits (please provide a brief description):* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Older Adults & Caregiver Check List; "To Go Bag"

## Personal

\_\_\_\_\_ Socks

\_\_\_\_\_ Long pants

\_\_\_\_\_ Sweatshirts

\_\_\_\_\_ Spare pair of shoes

\_\_\_\_\_ Medication list

\_\_\_\_\_ Hairbrush and comb

\_\_\_\_\_ Wet wipes

\_\_\_\_\_ Medications

\_\_\_\_\_ Current pictures of all family members

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Shirts

\_\_\_\_\_ Long sleeve shirts

\_\_\_\_\_ Under garments

\_\_\_\_\_ Deodorant

\_\_\_\_\_ Shaving items

\_\_\_\_\_ Dry shampoo

\_\_\_\_\_ Hand sanitizer

\_\_\_\_\_ Toothpaste & tooth brush

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Other: \_\_\_\_\_

## Animal

\_\_\_\_\_ Food

\_\_\_\_\_ Potty bags

\_\_\_\_\_ Blanket

\_\_\_\_\_ Shot records

\_\_\_\_\_ Medication list

\_\_\_\_\_ Hairbrush and comb

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Leashes

\_\_\_\_\_ Towel

\_\_\_\_\_ Collar with ID

\_\_\_\_\_ Dog treats

\_\_\_\_\_ Toys

\_\_\_\_\_ Veterinarians number

# Older Adults & Caregiver Check List

- \_\_\_\_\_ Drinking water (1 gallon/person/day)
- \_\_\_\_\_ Food (non-perishable; ready to eat)
- \_\_\_\_\_ Flashlight
- \_\_\_\_\_ Portable radio
- \_\_\_\_\_ Extra batteries  
(i.e.: flashlight, hearing aids, ..)
- \_\_\_\_\_ First aid kit
- \_\_\_\_\_ Hand-operated can opener
- \_\_\_\_\_ Light sticks
- \_\_\_\_\_ Waterproof matches
- \_\_\_\_\_ Cash or traveler's checks
- \_\_\_\_\_ Duct tape
- \_\_\_\_\_ Facial tissues
- \_\_\_\_\_ Wet toweletts
- \_\_\_\_\_ Scissors
- \_\_\_\_\_ Hand sanitizer
- \_\_\_\_\_ Phone chargers
- \_\_\_\_\_ Rain gear
- \_\_\_\_\_ Filter mask
- \_\_\_\_\_ Garbage bags paper plates, cups
- \_\_\_\_\_ Wrench & pliers
- \_\_\_\_\_ Disinfectant
- \_\_\_\_\_ Sun tan lotion
- \_\_\_\_\_ Gallon zip Lock Bags
- \_\_\_\_\_ Whistle (to signal for help)
- \_\_\_\_\_ Utility knife

- \_\_\_\_\_ Sensory items  
(i.e. head phones, puzzles, games)
- \_\_\_\_\_ Extra sets of Keys (house and car)

## Other medical supplies:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## Documents: *Seal in a water proof container*

- \_\_\_\_\_ Insurance cards
- \_\_\_\_\_ Medication list
- \_\_\_\_\_ Advance directives
- \_\_\_\_\_ Will
- \_\_\_\_\_ Deeds
- \_\_\_\_\_ Family contact phone sheet
- \_\_\_\_\_ Emergency contact phone list
- \_\_\_\_\_ Marriage certificate
- \_\_\_\_\_ Passports
- \_\_\_\_\_ Birth certificates
- \_\_\_\_\_ Important medical documents
- \_\_\_\_\_ Medical equipment
- \_\_\_\_\_ Documents/phone list

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ Other: \_\_\_\_\_

*All items should be stored together in an easily accessible location. You should annually review all items in your emergency kit and check all items with an expiration date, and replace as needed.*



# Caregiver & Older Adult Resources

**\*Alzheimer's Association:** [www.alz.org](http://www.alz.org); **1-800-272-3900**

Information and support for people with Alzheimer's disease and their caregivers. Operates a 24/7 helpline and care navigator tools.

**\*Alzheimer's North Carolina:** [www.alznc.org](http://www.alznc.org); **1-800-228-8738**

Alzheimer's North Carolina is dedicated to providing education, support and services to individuals with dementia, their families, health care professionals and the public while raising awareness and funding for research of a cause(s), treatment, prevention and cure for Alzheimer's disease and related dementias

**\*ARCH Respite Network:** [www.archrespite.org](http://www.archrespite.org)

Find programs and services that allow caregivers to get a break from caring for a loved one.

**\*Caregiver Teleconnection:** [www.caregiversos.org/caregiver-teleconnection/](http://www.caregiversos.org/caregiver-teleconnection/); **1-866-390-6491**

The Caregiver Teleconnection is a free, safe, and confidential program that uses the telephone to connect family caregivers with trusted professionals and other caregiver. Offers caregiver training, assistance, and support.

**\*Duke Alzheimer's Family Caregiver Support Program:** [www.geri.duke.edu/service/dfsp/about.htm](http://www.geri.duke.edu/service/dfsp/about.htm)

A source for help with Alzheimer's, memory disorders and elder care decisions. The Duke Family Support Program serves families and professionals concerned about or caring for persons with memory disorders in North Carolina, and Duke Employees seeking help with elder care decisions.

**\*Eldercare Locator:** [www.eldercare.gov](http://www.eldercare.gov), **1-800-677-1116**

Connects caregivers to local services and resources for older adults and adults with disabilities across the United States.

**\*Medicare-** [www.medicare.gov/caregivers](http://www.medicare.gov/caregivers); **1-800-Medicare**

**\*National Alliance for Caregiving:** [www.caregiveing.org](http://www.caregiveing.org)

A coalition of national organizations focused on family caregiving issues.

**\*NC Medicaid:** [www.ncdhss.gov/dma/medicaid/](http://www.ncdhss.gov/dma/medicaid/)

**\*NC Seniors' Health Insurance Program:** [www.ncshiip.com](http://www.ncshiip.com), **1-800-443-9354**

A program that offers one-on-one insurance counselling and assistance to people with Medicare and their families.

**\*Parkinson's Association of the Carolinas:** [www.parkinsonassociation.org](http://www.parkinsonassociation.org)

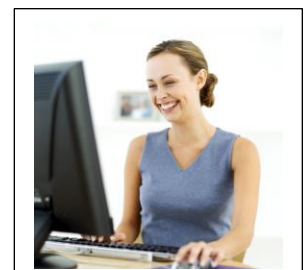
Resource for individuals and their families living in the Carolinas who are affected by Parkinson's disease

**\*Social Security Administration-1-800-772-1213**

**\*US Department of Health and Human Services:** [www.nia.nih.gov/health/publications](http://www.nia.nih.gov/health/publications)

Resources for individuals to include fitness, health, caregiving, etc...

**\*Veterans Administration:** [www.caregiver.va.gov](http://www.caregiver.va.gov), **1-855-260-3274**



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# Kerr Tar

## Area Agency on Aging

1724 Graham Avenue, PO Box 709, Henderson NC 27536 • Phone: 252-436-2040 • Web site: [www.kerrtarcog.org](http://www.kerrtarcog.org)