Respite Care Training Form (Written Instructions for Respite Care Providers) The information is strictly confidential

Name:	First	MI
Last	rust	1411
Nickname or Name Family	Member Prefers:	
Age: Date	e of Birth:/ Ge	ender: Male Female
Religion:	Disability:	
Primary Caregiver(s):		
Address:		
Address:Street	City	State Zip Code
Telephone:	Emergency Te	elephone:
Family Home Owner's Ins	surance Information	
Name:	Agent:	
Policy#:	Policy Effect	ive Date:
Wiedical Assistance, Title 2	Emergency Contacts	
	Emergency Contacts	
Person to be reached in car	se of emergency:	
Name	Relationship to Family Member	Telephone
preference:	be reached, please list other person	ns to contact in order of
1Rela	tionship to Family Member	Telephone
2		m
Name Rela	tionship to Family Member	Telephone
Circumstances in which pa	arent/guardian wish to be contacte	ed (i.e .fever, headache):
Primary Doctor:		Telephone:
Hospital Preferred		Telephone:

Medication Administration Record

Medication

Date/Time	Amount	Comments

Medication

Date/Time	Amount	Comments

Medication

Date/Time	Amount	Comments

Mobility The family member can walk (<i>check all that apply</i>):	
Unaided With a walker Using crutches With assistance With a cane With braces or splints	Prothesis, describe: Not at all, describe:
The family member uses a wheelchair (please check	all that apply):
Yes Manual Long distances only Pushes self short distances Sits unsupported	No Power Pushes self always Does not push self Needs support to sit
To transfer the family member (check all that apply)):
Can transfer self independently Needs Standby assistance Needs Hoyer lift assistance Instructions for transferring:	Can support weight for transfer Needs support from other person Needs no other assistance
Adaptive Transportation Instructions:	
Bedtime/Routines Please explain the sleeping routine for this family m	ember:

Toileting

Is the family member independent in	using the bathroom?	Yes	No
Please list all toileting aids (i.e. diapers, catheter, urinal, etc.)			
Would you like the family member's			No
Instructions for toileting:			
Behavior			
General behavior: (check all that app	ly)		
Usually easy going Shy/withdrawn Wary of new situations Suicidal Under-active Plays cooperatively with others	Physically aggressive Self abusive Overactive Needs continuous direction/Supervision Verbally aggressive/demanding Other:		
Please provide a description of the bel	naviors checked above:		
Please describe situations or things that	at may frighten the family	member:	
What activities/daily routines are diffi	cult for your family mem	ber?	

How does the family member occupy his/her time?
How does your family member handle frustration?
What signals will your family member give to indicate that he/she is about to become upset?
How does the family member respond to new people?
How are likes and dislikes expressed?
What do you do to help your family member through a difficult situation?
Has the family member ever acted out sexually toward self or others that you are aware of? Yes No If yes, please describe an instance of this behavior:
Other specific instructions, observations or comments:

Security and Emergency Information

Where is an extra key in case the respite provider is locked out?

Does your home have a security system? If so, what does the respite provider need to do to activate/deactivate the alarm?

Where can th	ne following	be located?
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Telephone(s):

Thermostat:

Fuse box:

First aid kit/medical supplies:

Main water line on/off:

Household Rules

Are visitors allowed? If so, who?

Other information/rules:

Are there pets in the home? Describe pet care: