# Angels In Guard home healthcare


## Senior Care Information Form

| | | |
|---|---|---|
| ☐Referral ☐Online Search ☐Social Media | Name of Referral: | |
| | Date [MM/DD/YYYY]: | |

## Contact information for person requesting care

| | | | |
|---|---|---|---|
| First name: | | Last Name: | |
| Phone: | | | |
| Email Address: | | | |
| Apt / Suite: | | | |
| Street Address: | | | |
| City: | | | |
| State / Province: | | | |
| Zip Code / Postal Code: | | | |

## General information of senior

| | |
|---|---|
| First name: | |
| Last name: | |
| House No / Apt / Condo / Unit / Room: | |
| Street Address: | |
| City: | |
| State / Province: | |
| Zip Code / Postal Code: | |
| Phone: | |

| | |
|---|---|
| D.O.B.: | |
| Gender: | |
| Married / Single / Divorced / Widow: | |
| First Language: (mother tongue) | |
| 2nd Language: (able to communicate) | |

## Current living situation of senior

☐ Lives at home alone
☐ Lives at home with Wife/Husband/Partner/Roommate
☐ Lives at home with Family
☐ Lives in assisted care facility
☐ Lives in private senior's residence
☐ Lives in hospital/Rehabilitation

| **ADDITIONAL COMMENTS:** |
|---|
| |

## Required frequency of senior care services

☐ Hourly routine care
☐ On call care (respite)
☐ Overnight care
☐ Live out 24/7 care
☐ Live in 24/7 care

## Senior assistance required

| **TYPE OF ASSISTANCE** | **No Assistance** | **Some Assistance** | **Full Assistance** |
|---|---|---|---|
| Bathing /Showering | ☐ | ☐ | ☐ |
| Toileting /Incontinence | ☐ | ☐ | ☐ |
| Dressing /Grooming | ☐ | ☐ | ☐ |
| Meal Prep /Eating | ☐ | ☐ | ☐ |
| Medication reminders | ☐ | ☐ | ☐ |
| Writing | ☐ | ☐ | ☐ |
| Bill payment | ☐ | ☐ | ☐ |
| Telephone Calls | ☐ | ☐ | ☐ |
| Housekeeping | ☐ | ☐ | ☐ |
| Pet(s) | ☐ | ☐ | ☐ |

## Mobility support required

☐ No assistance
☐ Cane
☐ Walker
☐ Wheelchair
☐ Require lift equipment

## Senior care emergency information

# Medical Specialists

| | | | | |
|---|---|---|---|---|
| **Name of Specialist:** | First: | | Last: | |
| Type of specialist: | | | | |
| Location: | | | | |
| Phone number and extension: | | | | |
| **Name of Specialist:** | First: | | Last: | |
| Type of specialist: | | | | |
| Location: | | | | |
| Phone number and extension: | | | | |
| **Name of Specialist:** | First: | | Last: | |
| Type of specialist: | | | | |
| Location: | | | | |
| Phone number and extension: | | | | |
| **Name of Specialist:** | First: | | Last: | |
| Type of specialist: | | | | |
| Location: | | | | |
| Phone number and extension: | | | | |
| **ADDITIONAL COMMENTS:** | | | | |

# Government nursing & social worker assigned to senior (optional)

| | | | | | |
|---|---|---|---|---|---|
| Reg. Nurse (Head) | | Name: | | Phone and Ext: | |
| Reg. Nurse (Home Visits) | | Name: | | Phone and Ext: | |
| Dietitian | | Name: | | Phone and Ext: | |
| Type of Therapist | | Name: | | Phone and Ext: | |
| Type of Therapist | | Name: | | Phone and Ext: | |

## Person(s) in charge of senior care (if different from person who filled out form):

| | | | | |
|---|---|---|---|---|
| **Primary** | First Name: | | Last: | |
| Relation to Senior | | | | |
| Full Address | | | | |
| Cell Phone number | | | | |
| Home Phone | | | | |
| Email | | | | |
| **Secondary** | First Name: | | Last: | |
| Relation to Senior | | | | |
| Full Address | | | | |
| Cell Phone number | | | | |
| Home Phone | | | | |
| Email | | | | |
| **ADDITIONAL COMMENTS:** | | | | |

# Family member information of senior:

| | | | | |
|---|---|---|---|---|
| **Family member** | First Name: | | Last: | |
| Relation: | | | | |
| Location: | | | | |
| Phone / Email: | | | | |
| **Family Member:** | First Name: | | Last: | |
| Relation | | | | |
| Address | | | | |
| Phone / Email: | | | | |
| **Family Member:** | First Name: | | Last: | |
| Relation | | | | |
| Address | | | | |
| Phone / Email: | | | | |
| **Family Member:** | First Name: | | Last: | |
| Relation | | | | |
| Address | | | | |
| Phone / Email: | | | | |

# Medical Diagnosis (current)-**(Diagnosis made by licensed medical professional)**

☐Dementia

☐Stroke

☐Diabetes

☐Macular Degeneration

☐Cancer

☐Parkinson's

☐Multiple Sclerosis

☐Heart Disease

☐Arthritis

☐**Other**

# List of medications

| Medication | Treatment for which condition |
|---|---|
| | |
| | |
| | |
| | |
| | |

# Routine non-medical appointments

| | | | |
|---|---|---|---|
| Appointment | | Frequency: | |
| Appointment | | Frequency: | |
| Appointment | | Frequency: | |
| Appointment | | Frequency: | |
| Appointment | | Frequency: | |
| Appointment | | Frequency: | |

# Food and drink

| | | | |
|---|---|---|---|
| Any food allergies | ☐YES ☐NO | List: | |
| Any food restrictions | ☐YES ☐NO | List: | |
| Food likes | ☐YES ☐NO | List: | |
| Food dislikes | ☐YES ☐NO | List: | |
| Need thickening agent | ☐YES ☐NO | Type: | |
| Is alcohol ok to drink | ☐YES ☐NO | List Restrictions: | |
| Dietitian recommendations | ☐YES ☐NO | List: | |
| **ADDITIONAL COMMENTS:** | | | |

# Care communication

| | | | |
|---|---|---|---|
| Most convenient form of communication for family member in charge of care | ☐PHONE ☐EMAIL ☐VIDEO CHAT | | |
| Is there access to a land line | ☐YES ☐NO | Tel #: | |
| Is there access to a cell phone | ☐YES ☐NO | Cell#: | |
| Does he/she own a computer | ☐YES ☐NO | List: | |
| Access to wireless internet | ☐YES ☐NO | Wireless network name (SSID): | |
| | | Password: | |

# Home environment

| | | | |
|---|---|---|---|
| Any concerns in living environment to be aware of | ☐YES ☐NO | List: | |
| Does he/she have pet(s) | ☐YES ☐NO | Assistance required: | |
| Does he/ she have a special place where they feel most comfortable | ☐YES ☐NO | Specify: | |
| Is there easy access to the washroom | ☐YES ☐NO | Specify: | |
| Is there easy access to the bath/shower | ☐YES ☐NO | Specify: | |
| Are stairs present in the place of residence | ☐YES ☐NO | List amount of floor levels (Inside/Out): | |
| Is there easy access to the street level outside the living environment | ☐YES ☐NO | Specify: | |

# Transportation of senior

| | | | |
|---|---|---|---|
| Will he/she be needing transportation with caregiver? | ☐YES ☐NO | | |
| Can senior drive vehicle ? | ☐YES ☐NO | | |
| Does he/she have a vehicle? | ☐YES ☐NO | Model: | |
| | | Year: | |
| | | Plate number #: | |
| Is vehicle insured? | ☐YES ☐NO | Company name: | |
| | | Contact Info: | |
| | | Policy number #: | |
| | | Expiry date: [MM/YY] | |
| Does caregiver have permission to drive vehicle? | ☐YES ☐NO | Details: | |
| Does caregiver have access to spare key? | ☐YES ☐NO | Specify where: | |
| Does caregiver have access to parking their vehicle at location? | ☐YES ☐NO | Specify where: | |
| Is a parking permit paper, sticker, key, or electronic device needed when parking? | ☐YES ☐NO | Specify: | |
| Does he/she have a registered parking permit for wheelchair access from gov't? | ☐YES ☐NO | Where is it kept: | |
| Does he/she have roadside assistance? | ☐YES ☐NO | Company name: | |
| | | Policy number #: | |
| **ADDITIONAL INFORMATION:** | | | |

## Senior activities

| TYPE OF ACTIVITY | DAY(S) | TIME(S) | LOCATION(S) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## Schedule information

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **DAY** | ☐ | Mon | ☐ | Tues | ☐ | Wed | ☐ | Thurs | ☐ | Fri | ☐ | Sat | ☐ | Sun |
| **TIME** | | | | | | | | | | | | | | |

## Care review

| | |
|---|---|
| Review care requirements every: | ☐3months ☐6months ☐Yearly |
| Date of next review:[MM/DD/YYYY] | |

## Signature

| | | | | |
|---|---|---|---|---|
| Person who filled out form: | First Name: | | Last Name: | |
| ☐Please certify that all the above information is true and correct:<br><br>*Please review before signing* | X | | | |
| Date of Signing [MM/DD/YYYY] | | | | |