RESPITE COACH DAILY CLIENT REPORT

NAME: ________________________ DATE: ________________________

CLIENT’S NAME: ________________________

Are there changes in your client’s physical health?  □ Yes □ No
If yes, please note the changes: __________________________________________

Are there changes in your client’s mental/emotional health?  □ Yes □ No
If yes, please note the changes: __________________________________________

Are there changes in the client’s environment or routine (ex: service, visitors, family, and sleep etc.)?  □ Yes □ No  If yes, please note the changes: __________________________________________

Are there any behavioral or psychological symptoms of dementia (ex: wandering, agitation, sun downing, hallucinations, delusions, paranoia etc.) to report that are new or have changed?  □ Yes □ No  If yes, please describe: __________________________________________

Do you have any concerns about this client or the Caregiver?  □ Yes □ No
If yes, please note the concerns: __________________________________________

Has there been a change in medication?  □ Yes □ No
If yes, please note the changes: __________________________________________

Is there anything more we could do to benefit this client?  □ Yes □ No
If yes, please note the changes: __________________________________________
What did you and your client do today?


Any comments or concerns you have about client:


What services do you provide for this client (check all)?

☐ Companionship      ☐ Meal Preparation      ☐ Activities
☐ Errands            ☐ Light Cleaning       ☐ Verbal Medication Reminder
☐ Caregiver Coaching ☐ Caregiver Education ☐ Caregiver Support

☐ Assisted with behavioral management (dementia (ex: wandering, agitation, sun downing, hallucinations, delusions, paranoia etc.), including:
Emergency Form

Must be completed before you are left alone with the individual. Take this form with you if you need to go to the hospital.

Individual's Name: ____________________________ Nickname: ________________________

Date of Birth: ________________________________

Primary Physician: ____________________________

IMPORTANT MEDICAL INFORMATION (i.e., allergies, blood type, diabetes, heart condition, epilepsy, etc.)

________________________________________________________________________

________________________________________________________________________

MEDICATIONS

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

HEALTH INSURANCE INFORMATION

Name of Insurance: ____________________________

Primary Insured: ____________________________ ID/Group #: ___________________________

Public Aid Case #: __________________________ Recipient #: __________________________

Medicare#: _________________________________

EMERGENCY CONTACTS

<table>
<thead>
<tr>
<th>NAME</th>
<th>PHONE NUMBERS (CELL, HOME &amp; WORK)</th>
<th>RELATIONSHIP</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Caregiver: ____________________________

Emergency Contact 1: __________________

Emergency Contact 2: __________________
In Case of Environmental Emergency

Should be kept on refrigerator/in plain sight

Here is the information needed in case of a break-in, fire, gas odor, flood or electrical problem.

<table>
<thead>
<tr>
<th>Police Department</th>
<th>911</th>
<th>Non-emergency phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Department</td>
<td>911</td>
<td>Non-emergency phone:</td>
</tr>
<tr>
<td>Poison Controls</td>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Gas Company</td>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Electric Company</td>
<td>Phone:</td>
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<tr>
<td>Water Company</td>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Security Company</td>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Homeowner Association</td>
<td>Phone:</td>
<td></td>
</tr>
</tbody>
</table>

We give you permission to authorize emergency work if necessary to prevent damage; we will be responsible for full payment of such work.

YES  NO  CALL FIRST

Caregiver Signature

Our Name:

House Address:

House Phone Number:

Cell Phone Number:

Closest Intersection:

Location of Electrical Breaker Box:

Location of Gas Shut off Valve:

Location of Water Shut off Valve:
Permission to Release Your Loved One
To an Authorized Person

To be used only if the caregiver runs into an emergency situation and is not able to return on time
Not used as a legal document for hospital

If, for any reason I, ___________________________, the caregiver for ___________________________, am not
able to receive my loved one at the end of the respite visit, I am authorizing the REST Companion to
release my loved one to the following people:

Name: ___________________________ Relation: ___________________________
Address: ___________________________
Phone: ___________________________

Name: ___________________________ Relation: ___________________________
Address: ___________________________
Phone: ___________________________

Name: ___________________________ Relation: ___________________________
Address: ___________________________
Phone: ___________________________

Name: ___________________________ Relation: ___________________________
Address: ___________________________
Phone: ___________________________

MUTUALLY AGREED AND SIGNED
I also acknowledge that prior to a REST Companion releasing my loved one to any of the above
listed individuals, that they must first show picture identification.

Caregiver Signature: ___________________________ Date: ___________________________
REST Companion Signature: ___________________________ Date: ___________________________
What is a Typical Day/Evening Like at Your Home?

Please explain a typical day in your loved one's life. Use additional paper if necessary.

Describe the general tone/environment:
- What are the normal routines?
- Tell me about interactions with others (people and pets).
- What are some of your loved one's coping mechanisms?
- Are there any restrictions that the REST Companion needs to know about?

Ask caregivers to be very specific
Try to capture routines and habits