Adult Day Care Center of Las Vegas
901 N. Jones Boulevard
Las Vegas, NV 89108

Nevada Senior Services, Inc.
702.648.3425
Fax: 702.648.1408

Adult Day Care Center of Henderson
1201 Nevada State Drive
Henderson, NV 89002

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:

_____

_____

_____

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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:

_____

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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

Name of Medication	Dose	Frequency

HEALTH INSURANCE INFORMATION

Name of Insurance: _____

Primary Insured: _____ ID/Group #: _____

Public Aid Case #: _____ Recipient #: _____

Medicare#: _____

EMERGENCY CONTACTS

NAME PHONE NUMBERS (CELL, HOME &WORK) RELATIONSHIP

Caregiver: _____

_____

Emergency Contact 1: _____

Emergency Contact 2: _____

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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.

Police Department	911	Non-emergency phone:
Fire Department	911	Non-emergency phone:
Poison Controls	Phone:	
Gas Company	Phone:	
Electric Company	Phone:	
Water Company	Phone:	
Security Company	Phone:	
Homeowner Association	Phone:	
	Phone:	

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:

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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:_____

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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