Caregiver Care Plan

Patient name: _____ Gender: _____

Date of birth: _____ dd / mm / yyyy Age: _____

Address: _____ Contact information: _____

MEDICAL CONDITIONS

Condition 1

Condition: _____ Healthcare provider for this condition: _____

Medicine taken: _____

Things that help (resting, exercise):

Condition 2

Condition: _____ Healthcare provider for this condition: _____

Medicine taken: _____

Things that help (resting, exercise):

Condition 3

Condition: _____ Healthcare provider for this condition: _____

Medicine taken: _____

Things that help (resting, exercise):

MEDICATIONS

Medication 1

Name of medicine: _____

Special instructions:

Dose: _____ When to take it: _____

Medication 2

Name of medicine: _____

Special instructions:

Dose: _____ When to take it: _____

Medication 3

Name of medicine: _____

Special instructions:

Dose: _____ When to take it: _____

Medication 4

Name of medicine: _____

Special instructions:

Dose: _____ When to take it: _____

GOALS OF CARE

Specify below:

INTERVENTIONS

Specify below:

RATIONALE

Specify below:

EMERGENCY CONTACTS

Contact 1

Name: _____ Relation: _____

Phone number: _____ Address: _____

Contact 2

Name: _____ Relation: _____

Phone number: _____ Address: _____

Contact 3

Name: _____ Relation: _____

Phone number: _____ Address: _____

HEALTHCARE PROVIDERS

Provider 1

Name: _____ Specialty: _____

Hospital/clinic: _____ Phone number: _____

Provider 2

Name: _____ Specialty: _____

Hospital/clinic: _____ Phone number: _____

Provider 3

Name: _____ Specialty: _____

Hospital/clinic: _____ Phone number: _____

CAREGIVER RESOURCES

Caregiver 1

Service provided (Driving, adult day care, meals, helpers, etc.):

Name of provider: _____ Contact information: _____

Caregiver 2

Service provided (Driving, adult day care, meals, helpers, etc.):

Name of provider: _____ Contact information: _____

Caregiver 3

Service provided (Driving, adult day care, meals, helpers, etc.):

Name of provider: _____ Contact information: _____

ADVANCED CARE PLANNING AND INSURANCE INFORMATION

Medical power of attorney: _____ Phone number: _____

Insurance provider: _____ Phone number: _____

INSTRUCTIONS AND IMPORTANT CONSIDERATIONS

Specify below: