QUICK REFERENCE CARE-PLAN TEMPLATE:

QUICK REFERENCE

PATIENT INFORMATION:

First and Last Name: _____

Preferred Name: _____

Date of Birth: _____

Address: _____

Primary Language: _____

PRIMARY CAREGIVER:

Name: _____

Relationship: _____

Phone: _____

Email: _____

EMERGENCY CONTACTS:

Name: _____

Relationship: _____

Phone: _____

Email: _____

PRIMARY CARE PHYSICIAN:

Name: _____

Clinic Address: _____

Phone: _____

Email: _____

PREFERRED HOSPITAL: _____

HEALTHCARE PROXY/POA:

Name: _____

Relationship: _____

Phone: _____

Email: _____

ALLERGIES (medications, foods, other):

_____
_____
_____

CURRENT MAJOR MEDICAL CONDITIONS:

_____
_____

_____
_____

CURRENT MEDICATIONS (name, dose, frequency)

Name	Reason-for-Taking-Meds	Dose	Frequency	Time

ASSISTIVE DEVICES:

☐ Walker ☐ Cane ☐ Wheelchair ☐ Oxygen ☐ Hearing Aid ☐ Eyeglasses

☐ Denture ☐ Other: _____

DAILY CARE ROUTINE:

MORNING:

_____

_____

MIDDAY:

_____

_____

EVENING:

_____

_____

MOBILITY AND SAFETY:

Fall risk: ☐ Low ☐ Moderate ☐ High

Assistance needed with: ☐ Walking ☐ Transfers

☐ Stairs

Safety notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

PERSONAL CARE:

Assistance needed with: ☐ Bathing ☐ Dressing

☐ Toileting ☐ Grooming

Notes:

_____

_____

NUTRITION:

Diet restrictions or preferences:

_____

_____

Swallowing difficulty: ☐ No ☐ Yes (describe):

_____

Encouragement needed: ☐ Eating ☐ Drinking

COMMUNICATION AND COGNITION:

Hearing: ☐ Good ☐ Impaired (uses hearing aids)

Vision: ☐ Good ☐ Impaired (uses glasses)

Cognitive status: ☐ Alert and oriented ☐ Mild memory loss ☐ Moderate dementia ☐ Severe dementia

Communication notes:

_____

_____

_____

_____

_____

_____

_____

_____

BEHAVIORAL OR EMOTIONAL NOTES:

_____

_____

CULTURAL OR SPIRITUAL PREFERENCES:

_____

_____

RED FLAGS (when to call for help):

_____

_____

_____

_____

ADDITIONAL NOTES:

_____

_____

Date of this care plan: _____