



Date Completed:

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READY, SET, PLAN - FOR CARE PARTNER ABSENCE

To be completed by the Person Living with Dementia

We all need to plan ahead. There may be a time that someone else may suddenly need to help care for you, such as if your care partner were to become sick.

If and when this happens, filling out the information below and keeping it updated with any changes will help. You are encouraged to share this plan with a family member, friend or neighbour you trust or at least to let them know of the existence of this plan and where it can be found.



Name:	
Preferred name (Nickname):	
Date of Birth:	Health Card Number:
Allergies:	
Language(s) spoken:	
Cultural background:	
Have a Do Not Resuscitate Certificate (DNR)? Yes No
If yes, DNRC#	Location of DNRC:
Have a Medical Alert Bracelet? Yes	No
If you were to become lost, what are some of shop, friend's home, etc.)?	of your favourite places to travel to (such as a local coffee

Have a pacemaker? Yes No

Other Implanted device? Yes No

Registered with the Police/Finding Your Way? Yes No

I Drive a vehicle Yes No If Yes, model and license plate:

Doctor/Specialist Name:	Phone	Number:
Dentist Name:	Phone	Number:
Eye Doctor Name:	Phone	Number:
Medical Conditions: Please include recent he	ospital visits and/or surg	geries.
Tip: It is helpful to attach a picture of yourse you travel to the coffee shop, post office, or		
HEALTH & PERSONAL CARE DE	PARTNER INFORMA	
HEALIH & PERSONAL CARE DE	:CISIONS, PROPERI	Y & FINANCIAL DECISIONS
Primary Care Partner Name:		
Relationship to You:		
Power of Attorney for Personal Care:		
Legally Appointed Substitute Decision	Maker:	
Substitute Decision Maker in Order (spo		blings, other relative):
Power of Attorney for Personal Care:	sase, parent, ermaren, s	amigo, other relative).
No Automatic SDM or POA for Persona	l Care No POA	for Personal Care
Power of Attorney for Property:		
Legally Appointed Power of Attorney fo	or Property:	
Power of Attorney for Property & Finan		
No POA for Property		
Public Guardian & Trustee:		
Please indicate where the POA paperwork c	an be found:	
Other People Information Can Be Shared W	ith: (please list name, re	lationship and phone number)
1. Name:	Relationship:	Phone:
2. Name:	Relationship:	Phone:
3. Name:	Relationship:	Phone:
4. Name:	Relationship:	Phone:
5. Name:	Relationship:	Phone:

3 ADVANCED CARE INFORMATION

It is important to also note any medical decisions that you would like made about your future medical care based on your values and beliefs. Developing a clear plan in advance can reduce family distress and help make sure that you receive the end-of-life care that you want.

Tip: You can get help with understanding advanced care planning and advanced health directives from your local Alzheimer Society.

Wishes:



Medication Name	Dose/Frequency	Any Special Instructions?
Location:		
Usual Pharmacy Name:	Phone N	Number:
This medication is current as of (date)) :	

5 ASSISTIVE DEVICES

Device Name	Yes or No		Description of use
Glasses	Yes	No	
Hearing Aids	Yes	No	
Dentures	Yes	No	
Communications Board	Yes	No	
Cane	Yes	No	
Walker	Yes	No	
Wheelchair	Yes	No	
Personal Location Device (e.g. GPS)	Yes	No	
Shower Bench	Yes	No	
Raised Toilet Seat	Yes	No	
Portable Oxygen	Yes	No	
Other:			

6 CARE YOU'VE RECEIVED IN THE HOME OR PROGRAMS ATTENDED IN THE COMMUNITY

Organization	Service	Contact Name & Phone Number
Organization	Service	Contact Name & Phone Number
Organization	Service	Contact Name & Phone Number
Organization	Service	Contact Name & Phone Number
Organization	Service	Contact Name & Phone Number



Do you have any of these symptoms? If yes, what is helpful to know to keep you feeling safe and well cared for?

Symptom	Yes or No	Details	
	Yes No	When does this happen?	
I have difficulty finding the right words or understanding others.	I don't know	What helps to make it better?	
	Voc. No.	When does this happen?	
I have difficulty planning or problem solving.	Yes No I don't know	What helps to make it better?	
		When does this happen?	
I have slowed thinking or difficulty concentrating.	Yes No I don't know	What helps to make it better?	
I have changes in mood or personality.	V N.	When does this happen?	
	Yes No I don't know	What helps to make it better?	
		When does this happen?	
I feel irritable or have angry outbursts.	Yes No I don't know	What helps to make it better?	
		When does this happen?	
I have confusion with time or place.	Yes No I don't know	What helps to make it better?	
I have difficulty recognizing familiar people or objects.	Yes No	When does this happen?	
	I don't know	What helps to make it better?	

Symptom	Yes or No	When does this happen? What helps to make it better?
		When does this happen?
When I leave my home, I sometimes get lost or confused about where home is.	Yes No	
	I don't know	What helps to make it better?
		When does this happen?
I have sleep problems (i.e., problems with sleep/wake cycle,	Yes No	
vivid nightmares, or physically moving around during sleep).	I don't know	What helps to make it better?



It is important for anyone helping to care for you to know who you are as a person, including what you like and do not like. Please provide some information about yourself in the following categories.
Your hobbies:
Your occupation (previous or current):
Your cultural background:
Your spiritual and religious beliefs and activities:
Your favourite television shows or music:
Your favourite foods:

Anything else you feel is important for others to know:

Do you need any help with the following activities?

Activity	Yes or No		Tips	
Bathing	Yes	No	If Yes, what tips are helpful to know?	
Eating (include favourite foods, special dietary needs)	Yes	No	If Yes, what tips are helpful to know?	
Dressing	Yes	No	If Yes, what tips are helpful to know?	
Grooming	Yes	No	If Yes, what tips are helpful to know?	
Medication	Yes	No	If Yes, what tips are helpful to know?	
Toileting (include incontinence products that are used)	Yes	No	If Yes, what tips are helpful to know?	
Walking/Mobility	Yes	No	If Yes, what tips are helpful to know?	

10 DAILY ROUTINE

Routine is important for all of us, but it can be especially helpful for you. Please describe what your average daily routine looks like to help others understand how you spend your time.

What time do you wake up?
What time do you eat breakfast?
How do you like to spend your time in the morning?

Other:

Morning

	What time do you eat lunch?
Afternoon	How do you like to spend your time in the afternoon?
	Other:
	What time do you eat dinner?
Evening	How do you like to spend your time in the evening?
	Other:
	What time do you go to bed?
Bedtime	Other:



If you choose, please ask your care partner to share with you any other information they think will be helpful to know about you and include it below.

For more information and support please contact your local Alzheimer Society:

Contact Name & Information:

References:

Administration for Community Living/U.S. Department of Health and Human Services. Disaster planning toolkit for people living with dementia. Retrieved from: https://nadrc.acl.gov/node/151

Alzheimer Society of Canada Disaster (2015). Be ready for an emergency department visit. Retrieved from: https://alzheimer.ca/sites/default/files/files/national/hospital/be_ready_for_an_emergency_department_visit_checklist_e.pdf

The Ontario Caregiver Organization (2020). COVID-19 Education and resources: Do you have a plan? Retrieved from: https://ontariocaregiver.ca/wp-content/uploads/2020/03/Ontario-Caregiver-Organization-Caregiver-Contingency-Plan.pdf

Also adapted and used with permission, Alzheimer Society of Niagara and The Alzheimer Society of British Columbia (2005).