Date Completed:

Alzheimer Society of Niagara | First Link®
1-403 Ontario St
St. Catharines, ON L2N 1L5

Tel: 905-687-3914 **Fax:** 905-687-9952
Toll-free: 1-877-818-3202

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.

1 YOUR INFORMATION

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 your favourite places to travel to (such as a local coffee shop, friend's home, etc.)?

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 hospital visits and/or surgeries.

Tip: It is helpful to attach a picture of yourself to this care plan should you become lost when, for example, you travel to the coffee shop, post office, or for groceries. This helps others to locate you.

2 CARE PARTNER INFORMATION

HEALTH & PERSONAL CARE DECISIONS, PROPERTY & 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 (spouse, parent, children, siblings, other relative):
- ☐ Power of Attorney for Personal Care:
- ☐ No Automatic SDM or POA for Personal Care
- ☐ No POA for Personal Care

Power of Attorney for Property:

- ☐ Legally Appointed Power of Attorney for Property:
- ☐ Power of Attorney for Property & Finances:
- ☐ No POA for Property
- ☐ Public Guardian & Trustee:

Please indicate where the POA paperwork can be found:

Other People Information Can Be Shared With: (please list name, relationship 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:

4 MEDICATION INFORMATION

This medication is current as of (date):

Usual Pharmacy Name: **Phone Number:**

Location:

Medication Name	Dose/Frequency	Any Special Instructions?

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**

7 DEMENTIA INFORMATION

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

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

8 HELPING OTHERS TO GET TO KNOW YOU

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:

9 EVERYDAY ACTIVITIES

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.

Morning

What time do you wake up?

What time do you eat breakfast?

How do you like to spend your time in the morning?

Other:

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

11 OTHER HELPFUL INFORMATION

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).