Senior

EMERGENCY

xxxxxxxxxxxx *Kit* xxxxxxxxxxxx

Welcome

You make sure your loved one gets the best care you can give. That job just got easier with the Caring For Your Parents: Senior Emergency Kit® from the Home Instead Senior Care® network.

Use this kit to keep your loved one's medical and financial information organised in one central place.

Inside this toolkit, you'll find:

IMPORTANT CONTACT *Information*

MEDICATION *Tracker*

ALLERGIES *and* **CONDITIONS** *Worksheet*

DOCTOR VISIT *Worksheet*

ADDITIONAL *Resources*

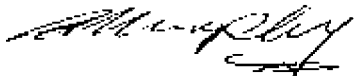
EMERGENCY *Checklist*

You can find extra copies of these materials on the Caring For Your Parents: Senior Emergency Kit website at www.HomeInstead.ie.

For more information and extra resources visit us at www.HomeInstead.ie

Thank you for providing such loving care to one of society's greatest resources – our older loved ones.

Sincerely,



Ed Murphy
CEO and Founder of Home Instead Senior Care in Ireland

Once completed, the Caring for Your Parents: Senior Emergency Kit® will contain sensitive health and financial information. As is always the case when dealing with such information, we encourage you to take steps to ensure the Kit is carefully safeguarded to protect your parent's privacy and prevent third parties from accessing and misusing the information.

Important

CONTACT

××× Information ×××

IMPORTANT INFORMATION FOR: _____

ADDRESS: _____

DATE OF BIRTH: _____ **PHONE** _____

Use the chart below to write down how to reach your loved one's important contacts, like doctors, solicitors and financial advisers.

CATEGORY	NAME/ BUSINESS	PHONE NUMBER(S)	ADDRESS	FAX	ACCOUNT/POLICY NUMBER	OTHER IMPORTANT INFORMATION
EMERGENCY						
GENERAL PRACTICE						
OPTOMETRIST						
OPHTHALMOLOGIST						
DENTIST						
SOLICITOR						
ACCOUNTANT						
SAFE DEPOSIT BOX						

Important Contact Information

CATEGORY	NAME/ BUSINESS	PHONE NUMBER(S)	ADDRESS	FAX	ACCOUNT/POLICY NUMBER	OTHER IMPORTANT INFORMATION
POWER OF ATTORNEY HOLDER CONTACT						
PARISH						
RELIGIOUS LEADER OR PRIEST						
OTHER MEDICAL SPECIALISTS						
BANK ACCOUNTS						
INSURANCE AGENTS & POLICIES						
PENSIONS & INVESTMENTS						

Important Contact Information

CATEGORY	NAME/ BUSINESS	PHONE NUMBER(S)	ADDRESS	FAX	ACCOUNT/POLICY NUMBER	OTHER IMPORTANT INFORMATION
OTHER CONTACTS (in case of emergency or death)						
UTILITIES & NEWSPAPERS (in case of long-term hospitalisation or death)						

For more information, please visit **HomeInstead.ie**

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To us, it's personal.

MEDICATION

Tracker

When you keep track of your loved one's medicines, it helps prevent accidents. Show this list to doctors and dentists so they can watch out for interactions and side effects.

Make sure you update this list after every doctor or dentist visit. You can also make copies of this list for relatives or caregivers who are involved with your loved one's care.

List all medicines, including:
Prescribed drugs, Over-the-counter (OTC) products, Vitamins, herbal products, and other supplements.

IMPORTANT INFORMATION FOR: _____

ADDRESS: _____

DATE OF BIRTH: _____ **PHONE** _____

MEDICATION	DESCRIPTION	DOSE	DOSE INSTRUCTIONS	PRESCRIBED BY OR OTC
Example: Ibuprofen	*Round, Orange Pill*	*200 mg*	*Take 2 tabs each morning with food*	*Dr. Jones*

Before visiting the doctor, remember to check medications to see if refills are needed.

Medication Tracker

MEDICATION	DESCRIPTION	DOSE	DOSE INSTRUCTIONS	PRESCRIBED BY OR OTC

For more information, please visit **HomeInstead.ie**

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ALLERGIES *and* CONDITIONS

Worksheet

Does your loved one have allergies? What about medical conditions that might affect care? Make sure emergency medical workers know about allergies and medical conditions by filling out the chart below.

(Include foods, seasonal allergies, and/or medications and conditions, such as heart problems, diabetes, arthritis, macular degeneration, etc.)

IMPORTANT INFORMATION FOR: _____

ADDRESS: _____

DATE OF BIRTH: _____ **PHONE** _____

ALLERGIES/ CONDITIONS	SIGNS/ SYMPTOMS	MEDICATION *(see medication tracker for dosage)*	EMERGENCY TREATMENTS OR OTHER IMPORTANT INFORMATION

For more information, please visit **HomeInstead.ie**

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DOCTOR VISIT

Worksheet

Write down your loved one's answers to the questions below. Then, use the answers to talk to a doctor about any concerns.

DOCTOR NAME: _____ **DATE OF VISIT:** _____

WHAT IS YOUR MAIN CONCERN RIGHT NOW?

DO YOU HAVE ANY NEW SYMPTOMS, SUCH AS PAIN?

WHAT CHANGES HAVE YOU NOTICED IN YOUR HEALTH SINCE YOUR LAST VISIT?

IF YOU CURRENTLY TAKE MEDICATION FOR PAIN OR ANY OTHER SYMPTOM, HOW IS IT WORKING?

HAVE YOU STARTED ANY NEW MEDICATIONS? WHAT ARE THEY? DO YOU HAVE ANY SIDE EFFECTS FROM THE MEDICINES YOU TAKE?

HAVE YOU SEEN OTHER DOCTORS BEFORE THIS VISIT? HAVE YOU HAD DIAGNOSTIC TESTS OR OTHER TREATMENTS? DO YOU WANT TO DISCUSS THOSE RESULTS?

Doctor Visit Worksheet

Use this page to write down what your loved one and the doctor discussed.

TESTS ORDERED

TEST RESULTS

RECOMMENDATIONS

MEDICATION INSTRUCTIONS

DIETARY RESTRICTIONS

NEXT STEPS

OTHER NOTES

For more information, please visit **HomeInstead.ie**

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EMERGENCY
Checklist

Name: _____

Address: _____

Date of Birth: _____ ☐ Male ☐ Female

EMERGENCY CONTACTS

Name: _____
Address: _____
Home Phone: _____
Work Phone: _____
Mobile Phone: _____

Name: _____
Address: _____
Home Phone: _____
Work Phone: _____
Mobile Phone: _____

MEDICAL DATA

Last Updated: _____
Doctor Name: _____
Doctor Name: _____

Blood Type: _____
Phone: _____
Phone: _____

MEDICAL PROBLEM	MEDICATION	DOSAGE	FREQUENCY

Religion: _____

Do you have a will? ☐ Yes ☐ No On file at: _____

Do you have a power of attorney? ☐ Yes ☐ No On file at: _____

Do you have a DNR Form? ☐ Yes ☐ No On file at: _____

MEDIAL CONDITION CHECKLIST

- ☐ No known medical conditions
- ☐ Abnormal EKG
- ☐ Adrenal Insufficiency
- ☐ Angina
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Cardiac Dysrhythmia
- ☐ Cataracts
- ☐ Clotting Disorder
- ☐ Coronary Bypass Graft
- ☐ Dementia
- ☐ Alzheimer's
- ☐ Diabetes/Insulin Dependent
- ☐ Eye Surgery
- ☐ Glaucoma
- ☐ Hearing Impaired
- ☐ Heart Value Prosthesis
- ☐ Hemodialysis
- ☐ Hemolytic Anemia
- ☐ Hepatitis – Type _____
- ☐ Hypertension
- ☐ Hypoglycemia
- ☐ Implantable Devices: _____
- ☐ Laryngectomy
- ☐ Leukemia
- ☐ Lymphomas
- ☐ Memory Impaired
- ☐ Myasthenia Gravis
- ☐ Pacemaker
- ☐ Renal Failure
- ☐ Seizure Disorder
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Vision Impaired
- ☐ Other: _____

ALLERGIES

- ☐ No known allergies
- ☐ Aspirin
- ☐ Barbiturate
- ☐ Codeine
- ☐ Demerol
- ☐ Insect Stings
- ☐ Latex
- ☐ Lidocaine
- ☐ Morphine
- ☐ Novocaine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ X-Rays Dyes
- ☐ Environmental: _____

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