

**CARING FRIENDS
ST. PAUL'S RESPITE MINISTRY
Contacts and Competency**

Friend Name: _____ **Date:** _____

Contact information: In order to follow your preferred procedure in case of an emergency, we need detailed information to locate you immediately. Please let us know if any of this information changes.

Responsible Party

Name: _____

Telephone numbers: _____

Relationship to Friend _____

Address: _____

Emergency contacts

Name: _____

Telephone numbers: _____

Name: _____

Telephone numbers: _____

Physician:

Name: _____

Telephone numbers: _____

Current diagnosis: _____

Current medications

Dosage

When taken

Does the Friend require any assistance in taking a medication?

Type of assistance required:

Diet

Is a special diet required? Are there any food allergies?

Is there any difficulty with eating? What accommodation is needed?

Mobility

What assistance is needed? _____

Any appliances – cane, walker, wheelchair: _____

Communication

Problems: _____

Non-verbal cues: _____

Vision:

Problems: _____

Aids used: _____

Hearing:

Problems: _____

Aids used: _____

Toileting:

Problems: _____

Assistance needed: _____

Mental Status:

Confused: _____ Forgetful: _____

Aware of: Environment _____ Time _____ Place _____ People _____

Confusion of people past with people present: Some _____ None _____

Lives in past: Often _____ Some _____ None _____

Other behaviors:

Comments
