**CAREGIVER WORKPLANNER**

**CAREGIVER DETAILS**

Name:

Gender:

Age:

Date of birth:

Address:

Phone number:

Email:

Emergency contacts:

Name:

Phone number:

Name:

Phone number:

**CARE RECEIVER DETAILS**

Name:

Gender:

Age:

Address:

Phone number:

Email:

* Occupation
* Working
* Not working
* Retired
* Student

Emergency Contacts:

Name:

Phone number:

**CARE RECEIVER’S FAMILY:**

**spouse /partner:**

* Lives in the same house
* Lives in the same city
* Lives in another city
* Lives in another country
* Phone number
* Preferred time to call

**Son:**

* Lives in the same house
* Lives in the same city
* Lives in another city
* Lives in another country
* Phone number
* Preferred time to call

**Daughter:**

* Lives in the same house
* Lives in the same city
* Lives in another city
* Lives in another country
* Phone number
* Preferred time to call

**Another close relative:**

* Lives in the same house
* Lives in the same city
* Lives in another city
* Lives in another country
* Phone number
* Preferred time to call

**Important phone numbers:**

Ambulance: Police:

Doctor: Hospital emergency:

**MEDICAL HISTORY**

Diabetes Yes No

Hypertension Yes No

Asthma Yes No

Stroke Yes No

Joint problem Yes No

Any other ailment Yes No

Any surgery Yes No

Any accidents Yes No

**Current diet**

|  |  |
| --- | --- |
| Breakfast |  |
| Midmorning |  |
| Lunch |  |
| Early evening |  |
| Late evening |  |
| Dinner |  |

Food likes:

Food dislikes:

Appetite: Normal Poor

Bowel movement Normal Disturbed

Urination Normal Poor Frequent Less

Continence: Normal Problem Wears diaper

Allergies if any:

Smoking: Yes No

Drinking: Yes No

Likes to meet people: Yes No

Hobbies:

Any other habits:

Walking: Normal Impaired

Corrected by:

Visual: Normal Impaired

Corrected by:

Hearing: normal Impaired

Corrected by

Coordination Normal Affected

Mental Normal Affected

**Any other habits:**

Brushing:

Bathing:

Shaving:

Dressing:

Toileting:

Eating:

**Date:**

Weighs: kgs

Height: cm

**Vital information**

**Date:**

Temperature: °C or °F

Pulse: beats per minute

Respiration: breaths per minute

Blood pressure: MM/Hg

Blood sugar: mg/dl or mmols/l

1. Fasting-
2. Before meals-
3. After meals-

**Permitted exercise for the care receiver:**

**Exercise** **Recommended duration**

Walking Minutes

Swimming Minutes

Cycling Minutes

Treadmill Minutes

Yoga Minutes

Passive physiotherapy Minutes

Others Minutes

**Dietary guidelines**

|  |  |  |  |
| --- | --- | --- | --- |
| Early morning |  |  |  |
| Breakfast |  |  |  |
| Midmorning |  |  |  |
| Lunch |  |  |  |
| Early evening |  |  |  |
| Late evening |  |  |  |
| Dinner |  |  |  |
| Bedtime |  |  |  |

**Daily Medication Chart**

Client

provider

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medication | Date | Dose | Time to be given | Remark | signature |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |
| 4. |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |