ARKANSAS Lifespan Respite COALITION

Take the Time



Information for Volunteer Respite Provider

The **Arkansas Lifespan Respite Coalition** is pleased to offer this guide that may help alleviate some of the worries associated with taking a break from stressful and strenuous daily caregiving duties. You can find additional resources at **http://www.choicesinliving.ar.gov/alrc.html**

FOR CAREGIVERS: We hope this booklet will help assure you that you have given your respite provider all the information they may need to take good care of your family member while you take a **well-deserved break**. The information provided by this brochure is very important; however, verbally communicate all your family member's needs directly to your respite provider as there will be additional information you would like to share with your provider.

FOR RESPITE PROVIDERS: You are offering a valuable service to a family who is very appreciative of your time, and they want to provide you with all the confidence you need to give them this "**gift of time**". This brochure will provide information to help you provide good care to the family member left in your charge, so that you may act appropriately in any situation.

CONSENT STATEMENT:

I, the undersigned parent or caregiver having legal custody of _____ (family member), do hereby authorize _____ (respite provider) to care for my family member. In the case of my absence or unavailability, _____ (respite provider) is hereby authorized to arrange medical treatment should my family member's condition warrant medical intervention. I will be responsible for payment for all such services provided to my family member.

Party Responsible for Patient:_____

Signature: _____ Date: _____

Note: This form is not meant to substitute for advice or forms obtained from your attorney or other advisor.

INFORMATION TO ASSIST THOSE WHO ARE RECEIVING OR PROVIDING RESPITE SERVICES

ABOUT OUR FAMILY

The _____family

Our address _____

_____

Our phone number_____

Our cell phone number_____

Family Caregiver contact Info:

_____

Family Member Name:

_____

Diagnosis:_____

_____

_____

Does your family member need or require:

Emergency Lifelines ____yes ____no

Medical Alert Bracelets ____yes ____no

Home Rules

May your family member go outside?

____yes ____no

If yes, how long? _____

In what specific areas of the yard?

_____

May your family member have visitors?

____yes _____no

If yes, who? _____

_____

When you are away, what are some other specific instructions for the respite provider?

_____

_____

_____

Emergency numbers:

Police 911

Fire 911

Poison Control_____

In case of emergency, and Family Caregiver cannot be reached, please call:

Name _____

Phone# _____

_____

Relationship to our family:

_____

Our doctor:

Dr._____

Phone #_____

Our pharmacy_____

Phone #_____

Other important numbers

_____

_____

_____

_____

About Our Family Member

Communication

Is your family member verbal? ____yes ____no

If no, how does he/she communicate wants & needs? _____

_____

Does he/she use a device in order to communicate? _____If so, are there any special instructions?

_____

_____

Current Other Medical Conditions

(Circle all that apply)

Alcoholism	Arthritis	Drug Abuse
Digestive/Intestinal	Heart	Hip Fracture
Osteoporosis	Allergies	Weight Loss
Depression	Hearing	Gynecological
High Blood Pressure	Falls	Obesity
Vision Problems	Diabetes	Cancer
Respiratory	Seizures	Dizzy Spells
Dementia	Other_____	

Prescription and OTC **medications** taken by the person with dosage/doctor information

_____

_____

_____

_____

_____

Does your family member have an allergy to any medications? ____yes ____no

If so, what medication?

_____

_____

Does your family member have any environmental allergies? ____yes ____no If so, to what?

_____

_____

Behavior

What's your family member's usual temperament?

_____

What makes your family member happy?

_____

Does this person experience agitation or hostility? _____ What situations tend to increase agitation and hostility? _____

_____

_____

What methods have you found to reduce agitation and hostility?_____

_____

_____

Does your family member have problems with memory?

____yes ____no

Does your family member run or wander away?

____yes ____no

Does your family member have any challenging behaviors? ____yes ____no

If so, how would you manage those behaviors?

_____

_____

_____

_____

Seizures

Does your family member have seizures? ____yes ____no

If so, please describe in detail (duration/how to handle) _____

_____

_____

_____

What happens afterward? _____

_____

_____

_____

Daily Living Activities

Does your family member use any adaptive equipment? _____

_____

_____

Where is the equipment located, and how or when should it be used? _____

_____

Is he/she able to self-feed? ____yes ____no

If no, what kind of help do they need?

_____

_____

Does this person require a special diet?

____yes ____no If yes, please describe.

_____

_____

_____

Any food allergies? _____

_____

Food likes or dislikes? _____

_____

Is this person able to self-toilet? _____

If no, what assistance is needed? _____

_____

_____

_____

Is this person incontinent? _____

If yes, how do you handle the situation?

_____

_____

Does your family member use diapers or protective undergarments? ____yes ____no

Is this person able to walk independently?

____yes ____no If no, what assistance and/or mobility devices are needed?

_____

_____

What assistance is needed for brushing teeth, dressing or bathing?

_____

_____

When is bedtime? _____

Nap time? _____

Any special positioning required? _____

_____

_____

Additional instructions: _____

_____

_____

_____

_____

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