family first

Caregiving Binder

Provide information about the PERSON GIVING CARE.

Caregiver: **Phone number:**

Address:

E-mail:

Check all that apply: ☐ Guardian ☐ Healthcare proxy ☐ Medical POA ☐ Financial POA

Complete the rest of this form with information about the PERSON RECEIVING CARE.

Care Recipient: **Date of birth:** **Age:**

Address:

Phone number:

ABOUT

In a few sentences, describe the person receiving care. Do they have food, music, or activity preferences? What religious, cultural, or spiritual beliefs are important to them? What does their family and support system look like? Are they a veteran or do they have significant life experiences caregivers should be aware of? Please share any information to help caregivers provide the best care. *Please also include a recent photo of the care recipient.*

MEDICAL & SURGICAL HISTORY

List current and past medical conditions and surgeries. Include dates surgeries were performed.

Date	Condition / Surgery

MEDICATIONS

Additional space for medications and providers can be found on pages 5 and 6 of this binder.

Medication 1:

Dosage & Frequency:

Route (oral, intravenous, etc.)**:**

Condition Prescribed For:

Medication 2:

Dosage & Frequency:

Route (oral, intravenous, etc.)**:**

Condition Prescribed For:

Medication 3:

Dosage & Frequency:

Route (oral, intravenous, etc.)**:**

Condition Prescribed For:

Medication 4:

Dosage & Frequency:

Route (oral, intravenous, etc.)**:**

Condition Prescribed For:

Medication 5:

Dosage & Frequency:

Route (oral, intravenous, etc.)**:**

Condition Prescribed For:

PROVIDERS INVOLVED IN CARE

Include all providers and physicians active in treating, evaluating, and prescribing medication to the person receiving care.

Name 1:

Specialty:

Practice (include city/town)**:**

Phone:

Name 2:

Specialty:

Practice (include city/town)**:**

Phone:

Name 3:

Specialty:

Practice (include city/town)**:**

Phone:

Name 4:

Specialty:

Practice (include city/town)**:**

Phone:

Name 5:

Specialty:

Practice (include city/town)**:**

Phone:

Notes:

HEALTH INSURANCE

Primary Insurance Carrier:

Subscriber:

DOB:
If different than care recipient

ID Number:

Phone number:
On the back of the card

Secondary Insurance Carrier:

Subscriber:

DOB:
If different than care recipient

ID Number:

Phone number:
On the back of the card

PREFERRED FACILITIES

Preferred Urgent Care:

Phone number:

Address:

Preferred Hospital:

Phone number:

Address:

OTHER AGENCIES INVOLVED (E.g. home care, Meals on Wheels, visiting RN/OT/PT, hospice)

Agency 1: _____ **Service Provided**: _____

Contact: _____ **Phone Number:** _____

Agency 2: _____ **Service Provided**: _____

Contact: _____ **Phone Number:** _____

Agency 3: _____ **Service Provided**: _____

Contact: _____ **Phone Number:** _____

Agency 4: _____ **Service Provided**: _____

Contact: _____ **Phone Number:** _____

Agency 5: _____ **Service Provided**: _____

Contact: _____ **Phone Number:** _____

EMERGENCY CONTACTS

Please list in the order of preference

Contact 1: **Relation:** ☐ **Healthcare Proxy**

Address: **Phone number:**

Contact 2: **Relation:** ☐ **Healthcare Proxy**

Address: **Phone number:**

ADVANCED CARE PLANNING

Check the Advanced Care Planning topics that you have discussed with your care providers.

☐ **Advanced Directive or Living Will**
This is a legal document (not a medical order), to appoint someone as your legal representative and provides instructions about how you wish to be treated and cared for at the end of your life. Because it is not a medical order, it is not used to help doctors, emergency medical technicians, or hospitals treat you in an emergency.

☐ **Power of Attorney**
This legal document is used for you to give a specific person the ability to make decisions for you when you are unable to do so. It can be a spouse, adult child, family member, or friend. You can also name an alternate person in case something happens to the primary person you name. The power of attorney is usually part of the Advanced Directive, but is sometimes a separate document. Sometimes, depending on where you live, it is called a "medical or healthcare power of attorney," "medical proxy," or "healthcare agent."

☐ **Physician / Medical Orders for Life-Sustaining Treatment (POLST or MOLST) or Physician Orders for Scope of Treatment (POST)**
This document, which varies by state, is a medical order signed by a medical professional and used for treatment. It is generally used when a person is nearing the end of life, such as with a terminal or serious illness. This is a document that your doctor can discuss with you during your Advanced Care Planning discussion. This does not name a "surrogate" or "medical proxy." This document would be used together with the Living Will/Advanced Directive to guide your loved ones and your doctors in the event that you are unable to make your own decisions. This is the most detailed and widely recognized version of a Do Not Resuscitate (DNR).

NEXT STEPS

For Caregivers
To foster collaboration between care providers and agencies, and to improve the quality of care, we highly encourage caregivers to share this Caregiving Binder with other members of the care recipient's Care Team. If you have not had a discussion with other members of the care recipient's team, now is an excellent time to start a conversation. **Should you need more help, do not hesitate to reach Family First's Care Experts by calling (877) 585-7090.**

For Care Recipients
Always ask your caregiver or medical provider to explain situations when you should call the doctor's office, report to an emergency room, or schedule a regular follow-up appointment. What are signs and symptoms you and/or your caregiver should look out for? Make sure you write on a calendar all appointments for all caregivers to see.

The following documents will be attached to this Caregiving Binder:

☐ **Copy of Insurance Cards**
☐ **Advanced Directive or Living Will**
☐ **Medical and/or Financial Power of Attorney**
☐ **Orders for Life-Sustaining Treatment** (POLST, MOLST, or POST)
☐ **Caregiving Blueprint**
☐ **Healthcare Proxy**
☐ **Estate Planning Documents**

MEDICATIONS

Medication 1: _____ **Dosage & Frequency:** _____

Route (oral, intravenous, etc.)**:**_____ **Condition Prescribed For:**_____

Medication 2: _____ **Dosage & Frequency:** _____

Route (oral, intravenous, etc.)**:**_____ **Condition Prescribed For:**_____

Medication 3: _____ **Dosage & Frequency:** _____

Route (oral, intravenous, etc.)**:**_____ **Condition Prescribed For:**_____

Medication 4: _____ **Dosage & Frequency:** _____

Route (oral, intravenous, etc.)**:**_____ **Condition Prescribed For:**_____

Medication 5: _____ **Dosage & Frequency:** _____

Route (oral, intravenous, etc.)**:**_____ **Condition Prescribed For:**_____

Medication 6: _____ **Dosage & Frequency:** _____

Route (oral, intravenous, etc.)**:**_____ **Condition Prescribed For:**_____

Medication 7: _____ **Dosage & Frequency:** _____

Route (oral, intravenous, etc.)**:**_____ **Condition Prescribed For:**_____

Medication 8: _____ **Dosage & Frequency:** _____

Route (oral, intravenous, etc.)**:**_____ **Condition Prescribed For:**_____

Medication 9: _____ **Dosage & Frequency:** _____

Route (oral, intravenous, etc.)**:**_____ **Condition Prescribed For:**_____

Medication 10 _____ **Dosage & Frequency:** _____

Route (oral, intravenous, etc.)**:**_____ **Condition Prescribed For:**_____

Notes:

PROVIDERS INVOLVED IN CARE

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Name 1: _____ **Specialty:** _____

Practice (include city/town)**:**_____ **Phone:** _____

Name 2: _____ **Specialty:** _____

Practice (include city/town)**:**_____ **Phone:** _____

Name 3: _____ **Specialty:** _____

Practice (include city/town)**:**_____ **Phone:** _____

Name 4: _____ **Specialty:** _____

Practice (include city/town)**:**_____ **Phone:** _____

Name 5: _____ **Specialty:** _____

Practice (include city/town)**:**_____ **Phone:** _____

Name 6: _____ **Specialty:** _____

Practice (include city/town)**:**_____ **Phone:** _____

Name 7: _____ **Specialty:** _____

Practice (include city/town)**:**_____ **Phone:** _____

Name 8: _____ **Specialty:** _____

Practice (include city/town)**:**_____ **Phone:** _____

Name 9: _____ **Specialty:** _____

Practice (include city/town)**:**_____ **Phone:** _____

Name 10: _____ **Specialty:** _____

Practice (include city/town)**:**_____ **Phone:** _____

Notes: