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?  ____If so, 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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