Alzheimers New Zealand

Personal Care Book

This is a book about a person with a dementia.
It is written by the person who knows that person best.

Making life better for all people affected by dementia | *Kia piki te ora mo ngā tāngata mate pōrewarewa*

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Making life better for all people affected by dementia
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Alzheimers New Zealand Incorporated is a charitable organisation with 23 member organisations located throughout the country.

Alzheimers New Zealand National Office supports the work of the member organisations and at a national level represents people with dementia, their carers and families, through advocacy, raising public awareness and providing information.

Alzheimers New Zealand has a range of information sheets and booklets available for people with dementia, their carers and families. Alzheimers member organisations located throughout New Zealand provide a variety of services in their local areas, to support all people affected by dementia.

Contact your local organisation for information and support on freephone 0800 004 001.

Contents

Introduction

This is a book about your family member who has a dementia.

As caring for a person with dementia can be demanding, there may come a time when you need to hand over the caring role to other people, to enable you to have time away. It is also possible that because of unforeseen emergencies, you cannot be with your family member for a period of time and the responsibility of caring must be left to others who do not know your relative as well as you.

In your absence, this *Personal Care Book* can enable the change-over to take place with minimal disruption, by describing the person you care for, their background and what is involved in their daily care requirements. The new carer, as well as gaining a better understanding of your family member, will also glean conversation topics from the book to help your relative feel more at ease.

You may need to change some of the information from time to time, as a means of reviewing your situation, noting changes and planning for the future. You may also wish to add or delete certain details so that this care book is relevant to your individual person.

This book contains information about:

Name: _____

Date of Birth: _____

Place of Birth: _____

Prefers to be known as: _____

(Nickname or Title e.g. Mr, Mrs, First Name)

Photo

Contact Numbers

In an emergency please contact:

(Name)	(Phone)	(Relation to person)

Names and phone numbers of family:

Names and phone numbers of friends:

Other important names and numbers:

GP _____

Specialist _____

Pharmacist _____

Optometrist _____

Dentist _____

Other health professionals _____

_____

Local Alzheimers Organisation _____

Personal Background

Full Name: _____

Surname

_____

Christian Name

Married To: _____

Brother's & Sisters Names: _____

_____

_____

_____

Children's Names & Where Residing: _____

_____

_____

_____

_____

_____

Family tree (a simple diagram; e.g. children, grandchildren, siblings)

Early Years – where were these spent?

Other Significant Places:

Name of Schools Attended

Primary

Secondary

Higher Education

University

Educational Attainments

Certificates

Diploma(s)

Degree(s)

Employment

(Trade or Profession)

(Previous Employees)

Experience in Armed Services

(Where Action Seen)

(Decorations)

What sports have been played or followed as a spectator?

Hobbies or interests?

(Include personal awards)

Groups/Clubs involved in?

(Honorary membership?)

What gives the most pleasure?

(e.g. Conversation topics, activities, pets, walking etc)

Any forthcoming events?

(e.g. Special Birthday, Golden Wedding)

Life Story

(Including major life events, favourite places visited, children and grandchildren)

These pages (3 of them) have been left for display of photographs, birth or marriage certificates, or anything which is important to the individual concerned. You may prefer to use duplicates or photocopies.

A Typical Day

Wake up time:

Usually about _____

No particular time _____

Is toilet visit urgent? _____

Is an early hot (or cold) drink taken? _____
(Name)

Breakfast:

Where is the usual place to eat? Name typical foods – particular likes/dislikes, or any food allergies?

_____

_____

Dressing in day clothes:

Usual time? _____

Is a daily walk taken? Yes / No

If so, what time? _____

Does the person walk alone or are they accompanied? _____

What activities occupy the morning? _____

_____

_____

Morning tea:

Is a mid morning snack taken – Usual time? _____

What kind of food/drink is offered for morning tea? _____

Lunch:

Usual time? _____

What does lunch usually consist of? Is it a full dinner or a light meal? _____

_____

Afternoon tea:

Is an afternoon snack taken – Usual time? _____

What kind of food/drink is offered for afternoon tea? _____

Is an afternoon rest taken? Yes / No

Usual time? _____

Other Afternoon Activities: _____

Evening Meal

Usual time? _____

What does dinner usually consist of? Is it a full dinner or a light meal? _____

_____

Evening Activities:

Is supper customary? Yes / No

Are regular visits made to the toilet? _____

Bedtime:

Usual Time? _____

(Note usual sleep pattern,eg. Often awake at night?)

_____

_____

Special Considerations

Name Social Activities:

Is watching TV a pastime? _____

Is reading magazines, paper, books an interest? _____

Is listening to music an interest? _____

Is playing an instrument an interest? _____

Is wandering a problem? _____

(If Yes, safety precautions to use, e.g., ID bracelet, door locks, etc)

Appearance and Clothes:

Special concerns ie. Shoes, hair, makeup: _____

Favourite colours: _____

Dislikes in terms of clothing: _____

Jewellery: _____

Is a hat/scarf generally worn when outside?: _____

Religious/spiritual requirements _____

Challenging behaviours:

Are certain behaviours a problem at different times of the day? _____

_____

_____

Are there triggers to these behaviours? _____

_____

Hiding or hoarding:

Are there particular places to check where objects are "stored"?

_____

_____

_____

_____

Repetition:

How do you handle this? _____

_____

_____

_____

Bathing

Is a bath tub or shower preferred? _____

How much assistance is needed? _____

Which time is preferred? _____

Is help required with dentures? _____

Is help required shaving? _____

Is help required with make-up? _____

How often is hair to be cut? _____

Legal Matters

Government Benefit Number _____

War Pension Number _____

NZ Superannuation Number _____

Community Services Card Number _____

Who is the legal next-of-kin?

_____

(Name)

_____

(Address)

_____

(Phone)

Does anyone hold an Enduring Power of Attorney? Yes / No

a. For property

_____

(Name and Phone)

b. For personal care and welfare

_____

(Name and Phone)

Does the person have a living will/advanced directive? Yes / No

If so, who holds the details of this advanced directive? Also, enclose a copy with this booklet.

_____

Who is the person's Legal Advisor/Lawyer?

_____

(Name and Phone)

Has a Will been made? Yes / No

If so, name the lawyer who holds it?

_____

Journal

As you know, the course of dementia is unpredictable. Changes in physical condition, such as flu, pneumonia or constipation, can often result in changes in mood and behaviour. By noting changes you can sometimes determine a pattern and sometimes a cause. It is particularly important to keep a record when medications are being tried. Recording these things in a journal will help you when you are talking with the doctor. Take the ***Personal Care Book*** with you to your appointments.

These journal pages can be used to record patterns of behaviour or as a summary of events that happen over time.

Date	Comments

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Medical Information

Please Note – It is important that these pages are kept up to date.

Date last updated:

What medical problems does the caregiver need to know?

Allergies? _____

Hearing? _____
(Details of hearing aid battery)

Vision? _____
(Are glasses for reading or daytime wear?)

Is incontinence a problem? _____
(Is help required with toileting/state normal times)

Is an I.D. bracelet or tracking device worn? _____

Is there a history of strokes/injuries? _____
(Causing immobility or pain)

Are there episodes of angina or seizures? _____

Does the person have diabetes? Yes / No
If so, are routine blood sugar tests done and how often?

_____

Are there any other medical problems that need to be noted?

_____

_____

_____

Medications:

Are there any medications to be taken on a casual basis? When?

_____

_____

Note any drug allergies: _____

_____

Oral Medication

(Note any difficulties with taking medication, or if it needs to be given with food)

Name
1. Medicine Type/Strength of dosage _____
2. Number of doses per day _____
3. Time of day – a.m. or p.m. _____

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Are there any injections required? Yes / No

_____

Name the drug, its strength and frequency, injection site (include site rotation)

Inhalers: Yes / No

_____

(Describe need for use – Name of drug – How often per 24 hours)

Eye Drops: Yes / No Left Eye / Right Eye / Both eyes

_____

(Describe need for use – name of drug – frequency of use)

Please note where medications are stored in the home.

_____

_____

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Space for more photos: