Personal Care Book

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

________________________________________________________________________

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*Personal Care Book 15*
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? 

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**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.

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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)

<table>
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<th>Name</th>
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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: