Illawarra Carer Respite Centre Emergency Care Plan

Contacts

Primary Carer:		*Person requiring care:*	
Name		Name	
Address		Address	
Phone	Age	Phone	Date of Birth
		Relationship to carer	
Language spoken at home:		Language spoken at home:	
Is an interpreter required:			
Aboriginal/ Torres Strait Islander:		Aboriginal/Torres Strait Islander:	

Emergency Contacts:	
Name	Phone
Relationship/Organisation	
Name	Phone
Relationship/Organisation:	
Name	Phone
Relationship/Organisation:	

Health Information:

General Practitioner		Phone:
Address		
Medicare number:	Ambulance number.	Medic-Alert Number
Medical/Hospital Insurance Fund Address		Membership number
Describe the disability and general state of health of the person requiring care		

Select the level of care required:

❒ **1** Meals only	❒ **2** Regular visits only	❒ **3** Fulltime care – mobile, no personal care required
❒ **4** Fulltime care – mobile, supervision of toileting and showering required		
❒ **5** Fulltime care – mobile, assistance with toileting, showering/bathing required		
❒ **6** Fulltime care assistance with lifting/transferring, toileting and showering required		
❒ **7** Other, specify		

Medication:

Where is medication kept		Dosette ❒ Blister pack ❒ Pharmacy bottles ❒
Pharmacist:	Address	Phone
Where is prescription for medication kept		
Allergies (especially to medication)		

Care required:

Supervision:
Toileting: When Equipment used:
Equipment used for Showering/Bathing: Number of people required: Other:
Lifting/Transferring: When Equipment used: Number of people required:
Meals/Diet
Other

Regular Care Services Used inhome and Away from Home:

Name of Service	Type of Service	Times Provided	Days Provided	Contact Name	Contact Number

Emergency Plan

Have any specific alternative care arrangements been made? If so, what are they?

Have financial arrangements been made for an emergency? If so, what are they?

Signed:…… Relationship to person requiring care:…… ..Date:……