META-CARE SENIOR CARE QUESTIONNAIRE

Thank you for providing the opportunity to provide the needed care for your loved one! The following questions while lengthy offers direction and information about how our care works and how we are hoping to assist your loved one(s).

Resident Name: _____

CARE RESPONSIBILITIES/SERVICES

Here are some of the services that will be considered during the course of care:

Social Pursuits

Going on walks/Sitting outside	Yoga/chair yoga	Reading/book clubs
Concerts in the park/Movie Theatre/Orchards/Museums	General companionship and conversation	Puzzles/Bingo/playing cards/board games

*The social pursuits may require the use of personal funds.

Personal Care

Assist with transfers from chairs, bath, etc.	Assist with toileting/bathing	Assist with personal grooming
Assist with dressing	Assist with walking	Assist with exercises

Facility

Private/Semi-Private Bathroom	Accessible Facility Throughout	Dining Area w/ table & chairs
Laundry Services	Cable TV in Room/Internet	Exterior Door Ramps
Personal Storage Space	Closet/Bed/Bed Linen	Outside Activity Space

Meals and Nutrition

Three daily nutritious meals and various snacks	Prepare and serve food/Special Diets/Assist with feeding	Clean, dry, and put away dishes

General Duties

Empty trash cans	Clean bedrooms and bathrooms	Care for pets/Water plants
Laundry and changing linens	Vacuum and sweep floors	Monitoring of the Resident(s) as directed by care directions

Health Care

Medication storage/Medication assistance for self-administration	Assistance with making appointments with health care services	Monitoring the Resident's health and bringing attention to health care providers

**Medical services should be provided by a licensed physician, therapist, or nurse.*

Transportation

Beautician Services	Faith-based events	Medical and dental appointments
Social visits to family and friends	Running errands for Resident(s)	Shopping for groceries and other items needed

NOTES ABOUT THE PERSON RECEIVING CARE

The person(s) that are being cared for can/cannot be left alone and has been diagnosed with _____. This can cause these changes in his/her behavior _____.

Allergies: _____.

Please include any essential information about dementia, Alzheimer's, food allergies, chronic pain, or other conditions.

SENIOR CARE – CARE NEEDS

This is a document that both of us will work with and develop together. The goal is to fill out this document at the start of the relationship, but update it as the senior's needs develop and change -- and the trust grows deeper between family members and Meta-Care.

Family Philosophy:

Describe how you want your loved one to be cared for. Explain what is important to your loved one and how independent is your loved one? Will s/he have a large say in day-to-day needs or does s/he need direction?

_____
_____

Specific Diagnoses:

Does your loved one have a medical diagnosis like diabetes, congestive heart failure or dementia? Let us know the specifics and history here.

_____
_____

Attention:

Can your loved one be left alone? Some seniors have certain illnesses that require supervision at all times. If this is the case, be very clear with us about this.

_____
_____

Religion:

Some seniors have certain preferences for their religion and Meta-Care is here to help. If this is the case, how can we assist with this?

_____
_____

Politics:

Some seniors have placed an importance on politics and Meta-Care is here to help. If this is the case, how can we assist with this (i.e. absentee ballot, transportation to precinct)?

_____
_____

Medication Monitoring:
Meta-Care will be providing your loved one to take medication at designated times, what happens if your loved one refuses to take the medication?

_____
_____

Physical or Cognitive Impairments:
Let us know of any physical or cognitive impairment your loved one has. How is their hearing? Do they need eye glasses? Does arthritis make getting out of bed difficult? Will your loved one know how to follow the caregiver's instructions?

_____
_____

Typical Reactions to Receiving Care:
If your loved one is very independent, make sure we know when and how to approach with offers of help. Do they reject assistance with one activity, but accept it with another? Do you have any tips to offer?

_____
_____

Handling Behavioral Issues:
This is a necessary area to cover if your loved one has a form of dementia. As mentioned above, you'll want to let us know what kinds of situations can trigger this behavior (such as aggression or another emotional state) in your loved one.

_____
_____

Additional Care:
What doctors is your loved one currently seeing or what additional care or therapies (such as physical therapy) are in progress or anticipated? Do the providers come to the house or will we need to bring your loved one to appointments?

_____
_____

In-Home Entertainment Options:
Does your loved one have a favorite television show? Does he or she like to read, be read to, listen to specific music, play cards, do puzzles, listen to the radio or do crafts? Do they have regular visitors in the home?

_____
_____

Visitors:
Does your loved one have regular visitors in the home? Who is allowed/not allowed? Are there any restrictions on how long your loved one can have visitors?

_____
_____

Sleep Preferences:
Talk about your loved one's typical sleep patterns and needs. Explain any particular rituals or habits they like to follow. Do they need a nap after lunch or following a doctor's appointment, etc?

_____
_____

Communication:
How often would you like to hear from us for an update? What particulars do you want to know about immediately or can wait? Do you want a phone call or text? Is the caregiver allowed to discuss your loved one's care with other relatives?

_____
_____

In an Emergency:
After calling emergency services, who else should be notified? List names and numbers here.

Name: _____ Phone Number: _____
Name: _____ Phone Number: _____
Name: _____ Phone Number: _____

SAMPLE DAILY SCHEDULE:
5:00am _____
6:00am _____
7:00am _____
8:00am _____
9:00am _____
10:00am _____
11:00am _____
12:00pm _____
1:00pm _____
2:00pm _____
3:00pm _____
4:00pm _____
5:00pm _____
6:00pm _____
7:00pm _____
8:00pm _____
9:00pm _____
10:00pm _____
11:00pm _____

Medication Prompting
Medication: _____
Dose: _____
Scheduled times to take: _____
Prescribing doctor: _____
Additional notes: _____

Medication: _____
Dose: _____
Scheduled times to take: _____
Prescribing doctor: _____
Additional notes: _____

Medication: _____
Dose: _____
Scheduled times to take: _____

Prescribing doctor: _____
Additional notes: _____

Medication: _____
Dose: _____
Scheduled times to take: _____
Prescribing doctor: _____
Additional notes: _____

*If further medication documentation is needed please let us know.

The Resident or its responsible representative has completed this to the best of their abilities.
Signature: _____
Printed Name: _____
Date: _____

*This document and the information in it is presented to be used solely as care direction for the use by Meta-Care.