CAREGIVER BINDER

BROUGHT TO YOU IN COLLABORATION WITH

The Gathering Place
Interfaith Ministries

Atomic
HOME SOLUTIONS

Gathering Place Interfaith Ministries is a non-profit 501c3 which serves Brazoria County families affected by dementia and provides education about prevention, diagnosis, and treatment of Alzheimer's disease.

DONATE HERE:

dear my future self

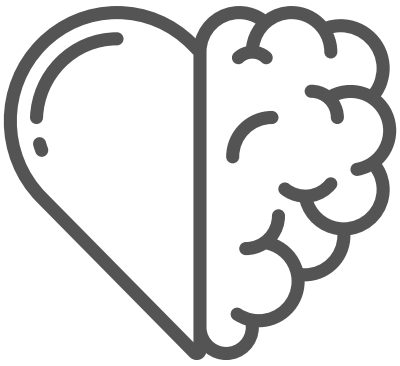
Today's Date

.....

Instruction

Writing a letter to your future self is a fun exercise that lets you reflect on your current life, as well as your goals and dreams.

Use this space to write a letter to yourself that you'll read at the beginning of the next month.



Dear me,

Sincerely,

Myself

self-care plan

MONTH

GOALS FOR MY MIND

.....

.....

.....

.....

MIND

Mental health

Mindfulness and self knowledge

Soul

Stimulation and fulfillment

GOALS FOR MY BODY

.....

.....

.....

.....

BODY

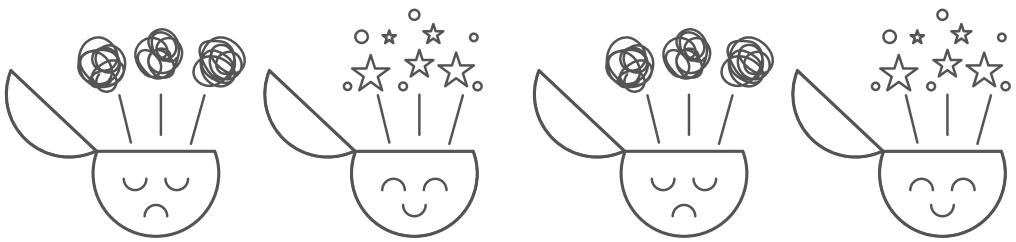
Self-care

Basic hygiene and body care

Improvement

Exercise, sleep and healthy food

GOOD RULES & HABITS I WANT TO LIVE BY



DAILY MOOD TRACKER

DATE

WEATHER

MOOD A.M.

MOOD P.M.

TODAY'S EMOTIONS

EXCITED	SAD
HAPPY	LONELY
RELAXED	DEPRESSED
GRATEFUL	ANXIOUS
PRODUCTIVE	ANGRY
LOVED	TIRED
CHEERFUL	FRUSTRATED
FINE	SICK
OK	EXHAUSTED
MEH	CONFUSED
BORED	INSECURE

WHAT AM I GRATEFUL FOR TODAY?

STRESS

ENERGY

WATER

WHAT WAS TODAY'S HIGH?

WHAT WAS TODAY'S LOW?

WHAT WORKED?

WHAT DIDN'T?

WHAT SELF-CARE ACTIVITIES DID YOU TRY TODAY?

NOTES & DOODLES

Self Assessment

Sun Mon Tue Wed Thu Fri Sat

How do I feel at this moment?

What am I putting off?

Overall Well-being

Yes No

I get enough sleep

Yes No

I spend time to recharge

Yes No

I have a healthy eating habit

Yes No

I keep my space clean

Yes No

I exercise my body regularly

Yes No

I take care of my hygiene

Yes No

GRATITUDE

/ /

TODAY I'M FEELING

POSITIVE AFFIRMATIONS

TODAY I'M GRATEFUL FOR

1 _____

2 _____

3 _____

SOMETHING I'M PROUD OF

_____

MORE OF THIS:	LESS OF THIS:

MY FAVORITE MOMENT THE DAY

_____

TOMORROW I LOOK FORWARD TO

_____

PRAYER REQUESTES

PRAYER REQUESTES	ANSWERED

CAREGIVER BINDER

Important Dates

January

February

March

April

May

June

July

August

September

October

November

December

DAILY MOOD TRACKER

DATE **WEATHER** 

MOOD A.M.  **MOOD P.M.** 

TODAY'S EMOTIONS

EXCITED	SAD
HAPPY	LONELY
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WHAT AM I GRATEFUL FOR TODAY?

STRESS 

ENERGY 

WATER 

WHAT WAS TODAY'S HIGH?

WHAT WAS TODAY'S LOW?

WHAT WORKED?

WHAT DIDN'T?

WHAT SELF-CARE ACTIVITIES DID YOU TRY TODAY?

NOTES & DOODLES

Emergency Information

In case of emergency call 911

	Name	Phone
PCP		
PCP 2		
Hospital		
Urgent Care		
Pharmacy		
Dentist		
Poison Control		
Gas Co		
Electric Co		
Water Co		
Fire Dept.		
Police Dept.		
Relative		
Relative		
Relative		
Neighbor		
Neighbor		
Family Friend		
Family Friend		

Medical Insurance Provider _____

Phone # _____

Policy # _____

Group # _____

Auto Insurance Provider _____

Phone # _____

Policy # _____

Group # _____

Utilities and Services Contact List

Electric Co. _____
Phone _____
Acct # _____
Emergency Phone _____
Contract Expiration _____

Gas Co. _____
Phone _____
Acct # _____
Emergency Phone _____

Water Co. _____
Phone _____
Acct # _____
Emergency Phone _____

Phone Co. _____
Phone _____
Acct # _____
Contract Expiration _____

Internet Co. _____
Phone _____
Acct # _____
Discount Expiration _____

Trash Co. _____
Phone _____
Acct # _____
Pickup Days _____

Other _____
Phone _____
Acct # _____
Emergency Phone _____

Other _____
Phone _____
Acct # _____
Emergency Phone _____

Home Emergency Info

Important Contacts	Contact Person	Phone
Landlord		
Property Manager		
Neighbor		
Neighbor		
Electrician		
Plumber		
HVAC Company		
Repair Person		

Location of Important Items

Items	Location
Breaker Box	
Water Shutoff	
Fire Extinguisher	
Flashlight	
Important Documents Folder	

Community Resources

	Name	Phone/Website	Contact Person	Notes
Senior Center				
Adult Daycare				
Area Agency on Aging				
Patient Support Group				
Family Support Group Transportation Services				
Meal Serviceser				
Home Care Agency				
Hospice				
Legal Services				

Caregiver/Agencies Information

Caregiving Agency _____

Address _____ Phone _____

Contact Person _____ Website _____

Notes: _____

_____

_____

Nursing and Rehab

Agency Name _____

Address _____ Phone _____

Contact Person _____ Website _____

Notes: _____

_____

_____

Housekeeping Service

Agency Name _____

Address _____ Phone _____

Contact Person _____ Website _____

Notes: _____

_____

_____

Lawn Service

Agency Name _____

Address _____ Phone _____

Contact Person _____ Website _____

Notes: _____

_____

_____

Other Agencies

Agency Name _____

Address _____ Phone _____

Contact Person _____ Website _____

Notes: _____

_____

_____

Agency Name _____

Address _____ Phone _____

Contact Person _____ Website _____

Notes: _____

_____

_____

Agency Name _____

Address _____ Phone _____

Contact Person _____ Website _____

Notes: _____

_____

_____

Agency Name _____

Address _____ Phone _____

Contact Person _____ Website _____

Notes: _____

_____

_____

Agency Name _____

Address _____ Phone _____

Contact Person _____ Website _____

Notes: _____

_____

_____

Caregiver Info

Name ______________________
Organization ______________________
Relationship ______________________
Contact # ______________________
Other ______________________

Type of Assistance

Domestic ☐ Medication ☐ Shopping ☐
Personal Care ☐ Appointments ☐ Paying Bills ☐
Meal Preparation ☐ Transportation ☐ Other ☐

Frequency of Visits

Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐

Name ______________________
Organization ______________________
Relationship ______________________
Contact # ______________________
Other ______________________

Type of Assistance

Domestic ☐ Medication ☐ Shopping ☐
Personal Care ☐ Appointments ☐ Paying Bills ☐
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Name ______________________
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Personal Care ☐ Appointments ☐ Paying Bills ☐
Meal Preparation ☐ Transportation ☐ Other ☐

Frequency of Visits

Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐

Caregiver Schedule

Month _____

	Time	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Week 1								
Week 2								
Week 3								
Week 4								

Our Medical Yellow Pages

	Name	Phone	Address
PCP			
PCP 2			
Gynecologist			
Optometrist			
Dentist			
Chiropractor			
Dermatologist			
Specialists:			

Hospital 1
Address
Phone

Hospital 2
Address
Phone

Clinic 1
Address
Phone
Hours

Clinic 2
Address
Phone
Hours

Insurance Information

Health Insurance Provider

Phone # _____ Website _____
Policy # _____ Username _____
Group # _____ Password _____
Name _____ ID # _____
Name _____ ID # _____

Secondary Health Insurance Provider

Phone # _____ Website _____
Policy # _____ Username _____
Group # _____ Password _____

Dental Insurance Provider

Phone # _____ Website _____
Policy # _____ Username _____
Group # _____ Password _____

Vision Insurance Provider

Phone # _____ Website _____
Policy # _____ Username _____
Group # _____ Password _____

Auto Insurance Provider

Phone # _____ Website _____
Policy # _____ Username _____
Group # _____ Password _____

Home Insurance Provider

Phone # _____ Website _____
Policy # _____ Username _____
Group # _____ Password _____

Flood Insurance Provider

Phone # _____ Website _____
Policy # _____ Username _____
Group # _____ Password _____

Doctor Visits

Date _____ Time _____ Doctor _____
Hospital/Clinic Name/City _____
Reason for Visit _____
Test Results _____
Prescriptions _____

Questions	Answers

Doctor Notes: _____

Date _____ Time _____ Doctor _____
Hospital/Clinic Name/City _____
Reason for Visit _____
Test Results _____
Prescriptions _____

Questions	Answers

Doctor Notes: _____

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Date _____ Time _____ Doctor _____
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Test Results _____
Prescriptions _____

Questions	Answers

Doctor Notes: _____

Doctor Visits

Name: ______________________________

Date __________ Doctor ______________________________
Hospital/Clinic Name/City ______________________________
Reason for Visit ______________________________
Test Results ______________________________
Prescriptions ______________________________
Notes ______________________________

Date __________ Doctor ______________________________
Hospital/Clinic Name/City ______________________________
Reason for Visit ______________________________
Test Results ______________________________
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Hospital/Clinic Name/City ______________________________
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Doctor Visits

Name: ____________________

Date __________ Doctor ____________________
Hospital/Clinic Name/City ____________________
Reason for Visit ____________________
Test Results ____________________
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Hospital/Clinic Name/City ____________________
Reason for Visit ____________________
Test Results ____________________
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Reason for Visit ____________________
Test Results ____________________
Prescriptions ____________________
Notes ____________________

Date __________ Doctor ____________________
Hospital/Clinic Name/City ____________________
Reason for Visit ____________________
Test Results ____________________
Prescriptions ____________________
Notes ____________________

Date __________ Doctor ____________________
Hospital/Clinic Name/City ____________________
Reason for Visit ____________________
Test Results ____________________
Prescriptions ____________________
Notes ____________________

Medications List

Medication	Reason Taken	Dosage	Frequency	Form	Prescribing Dr

Notes: _____

_____

MEDICATION ALLERGIES

_____

_____

Medications Log

Date	Time	Medication	Dosage	W/ Food?	Administered by
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	
	AM PM			Yes No	

Notes: ____

____

____

____

Blood Sugar Tracker

Date	Time	Level	Notes

Blood Pressure Tracker

Date	Time	Systolic	Diastolic	Pulse	Notes

Sleep Tracker

JAN / FEB / MAR / APR / MAY / JUNE / JUL / AUG / SEP / OCT / NOV / DEC

DATE	PM	AM	SLEEP QUALITY
1	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
2	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
3	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
4	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
5	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
6	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
7	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
8	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
9	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
10	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
11	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
12	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
13	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
14	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
15	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
16	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
17	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
18	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
19	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
20	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
21	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
22	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
23	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
24	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
25	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
26	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
27	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
28	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
29	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
30	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○
31	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	○ ○ ○ ○ ○

Food Journal

Week: ____________

Breakfast ____________
Lunch ____________
Dinner ____________
Snacks ____________

Rate your day ○ ○ ○ ○ ○

Breakfast ____________
Lunch ____________
Dinner ____________
Snacks ____________

Rate your day ○ ○ ○ ○ ○

Breakfast ____________
Lunch ____________
Dinner ____________
Snacks ____________

Rate your day ○ ○ ○ ○ ○

Breakfast ____________
Lunch ____________
Dinner ____________
Snacks ____________

Rate your day ○ ○ ○ ○ ○

Breakfast ____________
Lunch ____________
Dinner ____________
Snacks ____________

Rate your day ○ ○ ○ ○ ○

Breakfast ____________
Lunch ____________
Dinner ____________
Snacks ____________

Rate your day ○ ○ ○ ○ ○

Breakfast ____________
Lunch ____________
Dinner ____________
Snacks ____________

Rate your day ○ ○ ○ ○ ○

Notes: ____________

Food Journal

Week: ____________

Breakfast ____________
Lunch ____________
Dinner ____________
Snacks ____________

Rate your day ○ ○ ○ ○ ○

Breakfast ____________
Lunch ____________
Dinner ____________
Snacks ____________

Rate your day ○ ○ ○ ○ ○

Breakfast ____________
Lunch ____________
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Rate your day ○ ○ ○ ○ ○

Breakfast ____________
Lunch ____________
Dinner ____________
Snacks ____________

Rate your day ○ ○ ○ ○ ○

Breakfast ____________
Lunch ____________
Dinner ____________
Snacks ____________

Rate your day ○ ○ ○ ○ ○

Breakfast ____________
Lunch ____________
Dinner ____________
Snacks ____________

Rate your day ○ ○ ○ ○ ○

Breakfast ____________
Lunch ____________
Dinner ____________
Snacks ____________

Rate your day ○ ○ ○ ○ ○

Notes: ____________

Food Journal

Week: ____________

Breakfast ____________
Lunch ____________
Dinner ____________
Snacks ____________

Rate your day ○○○○○

Breakfast ____________
Lunch ____________
Dinner ____________
Snacks ____________

Rate your day ○○○○○

Breakfast ____________
Lunch ____________
Dinner ____________
Snacks ____________

Rate your day ○○○○○

Breakfast ____________
Lunch ____________
Dinner ____________
Snacks ____________

Rate your day ○○○○○

Breakfast ____________
Lunch ____________
Dinner ____________
Snacks ____________

Rate your day ○○○○○

Breakfast ____________
Lunch ____________
Dinner ____________
Snacks ____________

Rate your day ○○○○○

Breakfast ____________
Lunch ____________
Dinner ____________
Snacks ____________

Rate your day ○○○○○

Notes: ____________

Food Journal

Week: ______________

Breakfast
Lunch
Dinner
Snacks

Rate your day ○ ○ ○ ○ ○

Breakfast
Lunch
Dinner
Snacks

Rate your day ○ ○ ○ ○ ○

Breakfast
Lunch
Dinner
Snacks

Rate your day ○ ○ ○ ○ ○

Breakfast
Lunch
Dinner
Snacks

Rate your day ○ ○ ○ ○ ○

Breakfast
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Snacks

Rate your day ○ ○ ○ ○ ○

Breakfast
Lunch
Dinner
Snacks

Rate your day ○ ○ ○ ○ ○

Breakfast
Lunch
Dinner
Snacks

Rate your day ○ ○ ○ ○ ○

Notes:

Participant's Background Info

Birthdate _____

Place of Birth _____

Parents _____

_____

Siblings _____

_____

Schools Attended _____

_____

Cities Lived in _____

_____

Spouse _____

Children _____

_____

Pets _____

_____

Former Employment _____

_____

Other _____

_____

_____

_____

_____

_____

_____

_____

_____

Daily Routine

Wake up

Breakfast

Lunch

Nap

Walk/Exercise

Snack

Errands

TV Time

Shower/Bath

Dinner

Where is the Alexa located?

Activities to Avoid

Favorite Places to Go

Other

Food and Eating Habits

Food Allergies

Other Food Restrictions

Comfort Foods

Likes

Dislikes

Regular Breakfasts

Lunch Ideas

Favorite Snacks

Favorite Drinks

Favorites

Favorite Foods

Favorite Restaurants

Favorite TV Channels

Favorite Music

Favorite Shows

Favorite Movies

Favorite Places to go

Favorite Hobbies

Other _____

Other _____

Health Overview

DOB: _____

Height: _____

Weight: _____

Blood Type: _____

Latex Allergy? Yes ☐ No ☐

Glasses? Yes ☐ No ☐

Contacts? Yes ☐ No ☐

Prescription: _____

Medical History

- ☐ Acute Respiratory Distress Syndrome
- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety Disorder
- ☐ Arthritis (RA, OA)
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Back Injury
- ☐ Bladder Irritability
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Cancer
- ☐ COPD
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis A, B, C
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Irritable Bowel
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Mental Illness
- ☐ Metal Implants
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ PTSD
- ☐ Recurrent Skin Infections
- ☐ Recurrent UTI
- ☐ Ringing in ears
- ☐ Seizure Disorder
- ☐ Skin Abnormalities
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Vision Impairment

Other Medical Issues: _____

_____

_____

_____

Hospitalizations/ Significant Injuries: _____

_____

_____

_____

Surgeries/ Procedures: _____

_____

_____

_____

Needs and Self-Care Abilities

Activities	Independent	Needs Help	Notes
Bathing	☐	☐	
Dressing	☐	☐	
Grooming	☐	☐	
Walking	☐	☐	
Toileting	☐	☐	
Eating	☐	☐	
Medications	☐	☐	
Housework	☐	☐	
Laundry	☐	☐	
Cooking	☐	☐	
Shopping	☐	☐	
Driving	☐	☐	
Transportation	☐	☐	
Bills	☐	☐	
Mail	☐	☐	

Medical Devices and Equipment

	Needs Help	Notes:
Walker	☐	
Wheelchair	☐	
Hearing Aids	☐	
Glasses	☐	
Dentures	☐	
_____	☐	
_____	☐	
_____	☐	

Household Preferences

e.g. Keep the thermostat at 73 F

Care Considerations

Trigger	Reaction	Alternatives

Coping Techniques

Things I Do When I'm Sad

Things I do When I'm Bored

Things I Do When I'm Angry

Things I Do When I'm Stressed

Things That Stress Me Out

Warning Signs of Anxiety

Effective Coping Skills

Things That Distract Me

People I Can Talk To

Meltdown Tracker

Date _____ Time Started _____ Time Ended _____

Explain the Meltdown

Coping Skills Used to Handle Meltdown

Triggers/Causes

What Happened After?

Things to Do Next Time

Emergency Plan

Patient Representatives

Guardian

Name _____ Relationship _____
Address _____
Phone _____ Work Phone _____
Email _____
Notes _____

Health Care Proxy

Name _____ Relationship _____
Address _____
Phone _____ Work Phone _____
Email _____
Notes _____

Power of Attorney

Name _____ Relationship _____
Address _____
Phone _____ Work Phone _____
Email _____
Notes _____

Conservator

Name _____ Relationship _____
Address _____
Phone _____ Work Phone _____
Email _____
Notes _____

End of Life Wishes

In the event of a poor prognosis, would you choose to pursue any of the following:

	Yes	No		Yes	No
Hospitalization	☐	☐	Feeding Tube	☐	☐
Resuscitation	☐	☐	Extraordinary Measures	☐	☐
Surgery	☐	☐	Comfort Measures Only	☐	☐
Ventilator	☐	☐			

Health Care Proxy

Name _____ Relationship _____
Address _____
Phone _____ Work Phone _____
Email _____
Notes _____

Family/Friends to be Notified

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Attorney

Name _____ Firm _____
Address _____
Phone _____

Clergy

Name _____ Church _____
Address _____
Phone _____

Funeral Home

Name _____
Address _____
Phone _____

Cemetery

Name _____ Phone _____
Address _____
Lot # _____

Disclaimer: This page is for informational use only and does not take the place of a living will or legal advise.

Financial Information

Assetts	Bank/Company	Account #	Balance
Checking Acct			
Checking Acct			
Checking Acct			
Savings Acct			
Savings Acct			
Savings Acct			
Money Market Acct			
401K			
Retirement Acct			
Retirement Acct			
Investment Acct			
Investment Acct			
Investment Acct			
Safety Deposit Box			
Life Insurance			

Debts	Bank/Company	Account #/ Description	Balance
Mortgage			
Automobile			
Other Loans			
Credit Cards			

January Bills

Bill Type	Company	Due Date	Amt Due	Date Pd	Amt Pd	Pymt Method	Confirmation #

Notes

February Bills

Bill Type	Company	Due Date	Amt Due	Date Pd	Amt Pd	Pymt Method	Confirmation #

Notes

March Bills

Bill Type	Company	Due Date	Amt Due	Date Pd	Amt Pd	Pymt Method	Confirmation #

Notes

April Bills

Bill Type	Company	Due Date	Amt Due	Date Pd	Amt Pd	Pymt Method	Confirmation #

Notes

May Bills

Bill Type	Company	Due Date	Amt Due	Date Pd	Amt Pd	Pymt Method	Confirmation #

Notes

June Bills

Bill Type	Company	Due Date	Amt Due	Date Pd	Amt Pd	Pymt Method	Confirmation #

Notes

July Bills

Bill Type	Company	Due Date	Amt Due	Date Pd	Amt Pd	Pymt Method	Confirmation #

Notes

August Bills

Bill Type	Company	Due Date	Amt Due	Date Pd	Amt Pd	Pymt Method	Confirmation #

Notes

September Bills

Bill Type	Company	Due Date	Amt Due	Date Pd	Amt Pd	Pymt Method	Confirmation #

Notes

October Bills

Bill Type	Company	Due Date	Amt Due	Date Pd	Amt Pd	Pymt Method	Confirmation #

Notes

November Bills

Bill Type	Company	Due Date	Amt Due	Date Pd	Amt Pd	Pymt Method	Confirmation #

Notes

December Bills

Bill Type	Company	Due Date	Amt Due	Date Pd	Amt Pd	Pymt Method	Confirmation #

Notes

Bill Payment Checklist

Bill	Due	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
____________	______	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
____________	______	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
____________	______	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
____________	______	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
____________	______	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
____________	______	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
____________	______	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
____________	______	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
____________	______	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
____________	______	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
____________	______	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
____________	______	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
____________	______	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Planning for Important Health Care Decisions

In this section you will find printed forms from the Texas Department of Health and Human Services Website. You can find the latest updates of these forms at https://www.hhs.texas.gov/formas/advance-directives.

Note: The following is not a substitute for legal advice. While Gathering Place and Atomic Mom Blog provide the latest updated versions directly from the State of Texas website, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. Talk to a healthcare provider or an attorney before making any lasting legal decisions.

Contents:

For the Texas Department of Health and Human Services webpage containing the most up-to-date legal forms, scan this QR code with your phone's camera.

SCAN ME

DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

Advance Directives Act (see §166.033, Health and Safety Code)

Instructions for completing this document:

This is an important legal document known as an Advance Directive. It is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. These wishes are usually based on personal values. In particular, you may want to consider what burdens or hardships of treatment you would be willing to accept for a particular amount of benefit obtained if you were seriously ill.

You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician. Your physician, other health care provider, or medical institution may provide you with various resources to assist you in completing your advance directive. Brief definitions are listed below and may aid you in your discussions and advance planning. Initial the treatment choices that best reflect your personal preferences. Provide a copy of your directive to your physician, usual hospital, and family or spokesperson. Consider a periodic review of this document. By periodic review, you can best assure that the directive reflects your preferences.

In addition to this advance directive, Texas law provides for two other types of directives that can be important during a serious illness. These are the Medical Power of Attorney and the Out-of-Hospital Do-Not-Resuscitate Order. You may wish to discuss these with your physician, family, hospital representative, or other advisers. You may also wish to complete a directive related to the donation of organs and tissues.

DIRECTIVE

I,_____, recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care or treatment decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

_____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

_____ I request that I be kept alive in this terminal condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of medical care:

_____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

_____ I request that I be kept alive in this irreversible condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

Figure: 25 TAC §157.25 (h)(2)

OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Print Form

STOP DO NOT RESUSCITATE

This document becomes effective immediately on the date of execution for health care professionals acting in out-of-hospital settings. It remains in effect until the person is pronounced dead by authorized medical or legal authority or the document is revoked. Comfort care will be given as needed.

Person's full legal name _____ Date of birth _____ ☐ Male ☐ Female

A. Declaration of the adult person: I am competent and at least 18 years of age. **I direct that none of the following resuscitation measures be initiated or continued for me: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Person's signature _____ Date _____ Printed name _____

B. Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication:

I am the: ☐ legal guardian; ☐ agent in a Medical Power of Attorney; OR ☐ proxy in a directive to physicians of the above-noted person who is incompetent or otherwise mentally or physically incapable of communication.

Based upon the known desires of the person, or a determination of the best interest of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____ Printed name _____

C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication: I am the above-noted person's:

☐ spouse, ☐ adult child, ☐ parent, OR ☐ nearest living relative, and I am qualified to make this treatment decision under Health and Safety Code §166.088.

To my knowledge the adult person is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent or proxy. Based upon the known desires of the person or a determination of the best interests of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____ Printed name _____

D. Declaration by physician based on directive to physicians by a person now incompetent or nonwritten communication to the physician by a competent person: I am the above-noted person's attending physician and have:

☐ seen evidence of his/her previously issued directive to physicians by the adult, now incompetent; OR ☐ observed his/her issuance before two witnesses of an OOH-DNR in a nonwritten manner.

I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Attending physician's signature _____ Date _____ Printed name _____ Lic # _____

E. Declaration on behalf of the minor person: I am the minor's: ☐ parent; ☐ legal guardian; OR ☐ managing conservator.

A physician has diagnosed the minor as suffering from a terminal or irreversible condition. **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____

Printed name _____

TWO WITNESSES: (See qualifications on backside.) We have witnessed the above-noted competent adult person or authorized declarant making his/her signature above and, if applicable, the above-noted adult person making an OOH-DNR by nonwritten communication to the attending physician.

Witness 1 signature _____ Date _____ Printed name _____

Witness 2 signature _____ Date _____ Printed name _____

Notary in the State of Texas and County of_____. The above noted person personally appeared before me and signed the above noted declaration on this date:_____.

Signature & seal: _____ Notary's printed name:_____ *Notary Seal*

[Note: Notary cannot acknowledge the witnessing of the person making an OOH-DNR order in a nonwritten manner]

PHYSICIAN'S STATEMENT: I am the attending physician of the above-noted person and have noted the existence of this order in the person's medical records. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Physician's signature _____ Date _____

Printed name _____ License # _____

F. Directive by two physicians on behalf of the adult, who is incompetent or unable to communicate and without guardian, agent, proxy or relative: The person's specific wishes are unknown, but resuscitation measures are, in reasonable medical judgment, considered ineffective or are otherwise not in the best interests of the person. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Attending physician's signature _____ Date _____ Printed name _____ Lic# _____

Signature of second physician _____ Date _____ Printed name _____ Lic# _____

Physician's electronic or digital signature must meet criteria listed in Health and Safety Code §166.082(c).

All persons who have signed above must sign below, acknowledging that this document has been properly completed.

Person's signature _____ Guardian/Agent/Proxy/Relative signature _____

Attending physician's signature _____ Second physician's signature _____

Witness 1 signature _____ Witness 2 signature _____ Notary's signature _____

This document or a copy thereof must accompany the person during his/her medical transport.

MEDICAL POWER OF ATTORNEY
DESIGNATION OF HEALTH CARE AGENT

Advance Directives Act (see §166.164, Health and Safety Code)

I, _____ (insert your name) appoint:

Name: _____

Address: _____

_____Phone: _____

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

_____

_____

_____

_____

DESIGNATION OF AN ALTERNATE AGENT:

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved annulled, or declared void unless this document provides otherwise.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following person(s) to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

First Alternate Agent

Name: _____

Address: _____

_____ Phone: _____

Second Alternate Agent

Name: _____

Address: _____

_____ Phone: _____

The original of the document is kept at _____

_____

The following individuals or institutions have signed copies:

Name: _____

Address: _____

_____

Name: _____

Address: _____

_____

STATUTORY DURABLE POWER OF ATTORNEY

NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE EXPLAINED IN THE DURABLE POWER OF ATTORNEY ACT, SUBTITLE P, TITLE 2, ESTATES CODE. IF YOU HAVE ANY QUESTIONS ABOUT THESE POWERS, OBTAIN COMPETENT LEGAL ADVICE. THIS DOCUMENT DOES NOT AUTHORIZE ANYONE TO MAKE MEDICAL AND OTHER HEALTH-CARE DECISIONS FOR YOU. YOU MAY REVOKE THIS POWER OF ATTORNEY IF YOU LATER WISH TO DO SO. IF YOU WANT YOUR AGENT TO HAVE THE AUTHORITY TO SIGN HOME EQUITY LOAN DOCUMENTS ON YOUR BEHALF, THIS POWER OF ATTORNEY MUST BE SIGNED BY YOU AT THE OFFICE OF THE LENDER, AN ATTORNEY AT LAW, OR A TITLE COMPANY.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until:

(1) you die or revoke the power of attorney;
(2) your agent resigns, is removed by court order, or is unable to act for you; or
(3) a guardian is appointed for your estate.

I, _____ (insert your name and address), appoint _____ (insert the name and address of the person appointed) as my agent to act for me in any lawful way with respect to all of the following powers that I have initialed below. (YOU MAY APPOINT CO-AGENTS. UNLESS YOU PROVIDE OTHERWISE, CO-AGENTS MAY ACT INDEPENDENTLY.)

TO GRANT ALL OF THE FOLLOWING POWERS, INITIAL THE LINE IN FRONT OF (O) AND IGNORE THE LINES IN FRONT OF THE OTHER POWERS LISTED IN (A) THROUGH (N).

TO GRANT A POWER, YOU MUST INITIAL THE LINE IN FRONT OF THE POWER YOU ARE GRANTING.

TO WITHHOLD A POWER, DO NOT INITIAL THE LINE IN FRONT OF THE POWER. YOU MAY, BUT DO NOT NEED TO, CROSS OUT EACH POWER WITHHELD.

_____ (A) Real property transactions;
_____ (B) Tangible personal property transactions;
_____ (C) Stock and bond transactions;
_____ (D) Commodity and option transactions;
_____ (E) Banking and other financial institution transactions;
_____ (F) Business operating transactions;
_____ (G) Insurance and annuity transactions;
_____ (H) Estate, trust, and other beneficiary transactions;
_____ (I) Claims and litigation;
_____ (J) Personal and family maintenance;
_____ (K) Benefits from social security, Medicare, Medicaid, or other governmental