Information *for* Carers

Australian Government

Emergency Care Plan

Carer Name _____

Relationship to person requiring care _____

Address _____

_____

Telephone home _____ work _____

mobile _____

Person requiring care

Name _____ Age _____

Address _____

_____

Telephone _____ mobile _____

Language Spoken _____

Emergency Contacts

Name _____

Relationship/Organisation _____

Telephone home _____ work _____

mobile _____

Name _____

Relationship/Organisation _____

Telephone home _____ work _____

mobile _____

Name _____

Relationship/Organisation _____

Telephone home _____ work _____

Mobile _____

Health Information

Details about the person I care for

Person's illness or disability _____

Doctor Name _____

Address _____

Telephone _____

Medicare number _____

Health Insurance Fund Name of Fund _____

Telephone _____

Membership number _____

Ambulance Fund/Registration number _____

Medic-Alert number _____

Description of care needs _____

_____

_____

Care Required

The person I am caring for needs

- ☐ Meals only
- ☐ Regular visits only
- ☐ Full-time care – mobile, no personal care required
- ☐ Full-time care – mobile, supervision of toileting and showering required
- ☐ Full-time care – mobile, assistance with toileting, showering/bathing required
- ☐ Full-time care – assistance with lifting/transferring, toileting and showering/bathing required
- ☐ Other _____

Supervision _____

Toileting When _____

_____

Equipment used _____

_____

Showering / Bathing When _____

_____

Equipment used _____

Number of people required _____

Other _____

Lifting / Transferring When _____

_____

Equipment used _____

Number of people required _____

Diet _____

Other _____

_____

Medication

Regular medication

Name	Dose	Special Instructions

Allergies _____

_____

Regular Home & Community Care Services

Please advise if care arrangements change

Organisation _____

Service Provided _____

Contact Name _____

Telephone _____

Organisation _____

Service Provided _____

Contact Name _____

Telephone _____

Organisation _____

Service Provided _____

Contact Name _____

Telephone _____

Emergency Plan

In an emergency my contacts will: _____

_____

_____

My emergency financial arrangements are: _____

_____

_____

Signed _____

Relationship to person requiring care _____

Date _____

WHERE CAN I GET EXTRA COPIES OF THE PLAN?

Extra copies of the Emergency Care Kit are available from your **Commonwealth Respite and Carelink Centre**. You can contact them on **1800 052 222***.

*Free call from local phones, mobile calls at mobile rates

P3-4516 (0809)

QUESTIONS FOR MY DOCTOR

1. What is the diagnosis?
   How long is it likely to last?
2. What can I do to improve my health?
3. What is the name of the new medicine you have prescribed for me?
4. What does the medicine do and how should I use it?
5. How long should I use it?
6. Are any side effects likely or should I expect to feel any different while taking this medicine?
7. When should the medicine be reviewed or stopped?
8. Please fill in/check my Medi-list. Will this medicine interact with other medicines I use?

QUESTIONS FOR MY PHARMACIST

1. How and when is the best way to use this medicine?
2. What food, drink, activity or storage might affect how well this medicine works?
3. Are any side effects likely or should I expect to feel any different while taking this medicine?
4. What can I do to reduce the chance of any side effects?
5. Please fill in/check my Medi-list. Will this medicine interact with other medicines I use?
6. What should I do if I miss a dose?
7. Can you give me any information about this medicine?
8. Using medicines is a problem for me because of my sight/swallowing/strength/memory. How can you help me?

USING THIS MEDI-LIST

- Ask your pharmacist and doctor to fill in your Medi-list showing ALL the medicines you use regularly (including medicines prescribed by doctors and medicines bought from pharmacies, supermarkets or health food shops).
- Update your Medi-list whenever a new medicine is added or your medicine/s change.

DOCTOR _____

Address _____

_____

Telephone _____

PHARMACIST _____

Address _____

_____

Telephone _____

Information *for* Carers

MEDI-LIST

Australian Government

Name _____

Address _____

_____

Telephone _____

Medicare number _____

Safety Net number _____

Concession card type

Gold / White (DVA) _____

Health Care Card _____

Pensioner Concession Card _____

P3-4516 (0809)

ALLERGIES: _____

DATE STARTED	NAME OF MEDICINE		WHAT'S IT FOR	DOSE / TIMING	SPECIAL INSTRUCTIONS
	Generic name / Brand name	Strength			
/ /					
/ /					
/ /					
/ /					
/ /					
/ /					
/ /					
/ /					

Phone your Commonwealth Respite and Carelink Centre on 1800 052 222* for extra copies of this card.
*Free call from local phones, mobile calls at mobile rates.

Information *for* Carers

CARER EMERGENCY CARD

I CARE FOR A PERSON WHO IS DEPENDENT ON MY ASSISTANCE

NAME OF CARER

RELATIONSHIP TO PERSON BELOW

NAME OF PERSON REQUIRING CARE

If I am sick or in an accident this person
REQUIRES IMMEDIATE ATTENTION
Emergency details on the back of this card

EMERGENCY CONTACTS

NAME
RELATIONSHIP / ORGANISATION
TELEPHONE

NAME
RELATIONSHIP / ORGANISATION
TELEPHONE

NAME
RELATIONSHIP / ORGANISATION
TELEPHONE

D0217 Feb 2011