SUBSTITUTE CARE PLAN (Attach Fact Sheet)

Individual Receiving Substitute Care: _____

Life Sharing Provider will be away from: _____to_____

Phone Number and Location of Life Sharing Provider while Substitute Care is being provided: _____
_____
_____

MEDICATIONS: (List below or attach list of current medications)
Medication: Name, Dose, Time to give, Special Instructions
_____
_____
_____
_____

APPOINTMENTS: (while in substitute care)
(Doctor's office, physical therapy, beauty/barber, visit friends, activities, etc. Include date, time, location, contact name, phone number)
1. _____
2. _____
3. _____
Does the individualal n need assistance with (indicate yes or no):
Eating / Drinking: Y N Special Diet: Y N Preparing Meals: Y N
Bathing: Y N Toileting: Y N Skin / Hair: Y N Shaving: Y N
Walking: Y N Climbing Stairs: Y N Dressing: Y N
Taking Medicationons: Y N Money: Y N

(Indicate yes or no):
Can individual answer / make telephone calls?
Could individual get out of house in case of fire?
Can individual be left alone for short periods?

Does the individual use (indicate yes or no):
Dentures_____ Hearing Aid_____ Cane _____ Walker _____
Other _____

Likes_____
Dislikes_____

<u>Sleep</u>: (General Routine)
Bed time _____ Wake time _____ Nap _____
<u>Meals</u>:
Breakfast time _____ Lunch time _____
Dinner time _____ Snacks _____
Food allergies _____
Special eating instructions _____
_____

Additional comments: _____
_____
_____

Where Life Sharing Provider can be contacted