DEMENTIA SUPPORT
Northwest

Welcome to Amy's Place Respite Program!

Name of Participant:_____

Age:_____Primary Diagnosis:_____

Address:

_____

Person Filling Out this Form:_____

Relation to Participant: _____

Caregiver Contact:

Phone #: _____

Email: _____

Thank you for taking the time to fill out this form. The goal of our respite program is to create a safe, joyful, and engaging environment for every individual who joins us. By sharing a little about the needs and interests of the person receiving care, you're helping us provide personalized, respectful care that honors who they are.

Please answer the following questions with as much information as you are comfortable sharing—every detail helps us better support them while they're with us.

Family, History, and Background

Where did they grow up?

_____

_____

Known Family History: Siblings? Family trips? Exeteric upbringing?

Veteran Status? If so, what branch of the military?

☐ Check if Non-Applicable

Relationships

Friends? What do they enjoy doing with their friends?

Marital status?

Do they have children? Grandchildren? How many?

Education

What was the highest level of education they received? What were their academic interests? What did they study?

_____

_____

_____

Employment and Hobbies

What was their primary occupation?

_____

_____

_____

What do they love to do? What were/are their hobbies?

_____

_____

_____

What other interests do they have?

_____

_____

_____

Communication

How does this person typically communicate (verbally, by using gestures, nonverbal cues)?

_____

_____

_____

Is there anything or anyone we should NOT ask/talk about? Politics? PTSD? Sports?

_____

_____

_____

What strategies have you found helpful when they're feeling anxious or upset?

_____

_____

_____

Is there anything else we should know to ensure your recipient has the best experience possible here at Amy's Place? What is something they are proud of/ take pride in?

_____

_____

_____

Medical conditions/current medications/advance care plan/POLST (Physical Orders For Life Sustaining Treatment)? Please make sure staff are aware and have the proper paperwork if this applies to this person receiving care.

_____

_____

_____

Wandering tendencies, check all that apply:

- ☐ Wanders from social gatherings or activities if not constantly engaged
- ☐ Actively exits or tries to leave designated areas
- ☐ Experiences hallucinations
- ☐ Struggles with thoughts of abandonment or victimization
- ☐ Has difficulty moderating aggression
- ☐ Has difficulty moderating anxiety or fear
- ☐ None of these has been a concern.

Mobility, check all that apply:

- ☐ Walks independently
- ☐ Walks with an assistive device (e.g., cane, walker)
- ☐ Walks holding onto furniture or walls
- ☐ Has difficulty with stairs due to balance or foot coordination
- ☐ Has difficulty with stairs because of stamina
- ☐ Has difficulty walking on a flat surface due to balance or foot coordination
- ☐ Has difficulty rising from a seated position without assistance
- ☐ Independently rises, but struggles to gain balance

Please note: Staff and volunteers are not able to provide hands-on assistance (e.g., lifting or giving a “hand up”) when standing or walking. Participants must be able to manage mobility needs with verbal support or cues only.

Mobility /Assistive devices, Underline all that apply:

Uses cane/brace/walker (glasses, reading glasses/hearing aids, dentures / other:_____

Current smoker? Yes/No (Staff cannot assist with smoking. **Please do not send cigarettes**.)

Normal bedtime:_____ normal wake-up time:_____ normal nap time:_____

Emergency Contact Information

Primary Care Partner Contact **Name: _____** **Relationship: _____** **Phone #: _____** **Alternate Phone # : _____** **Email (optional): _____**	**Medical Contact Information** **Physician Name: _____** **Physician's phone #: _____** **Office location:_____** **Neurologist:_____**
Emergency Contact #1 **Name: _____** **Relationship: _____** **Phone #: _____** **Alternate Phone # : _____** **Email (optional): _____**	**Emergency Contact #2** **Name: _____** **Relationship: _____** **Phone #: _____** **Alternate Phone # : _____** **Email (optional): _____**

Medical Emergencies Policy, Initials:_____

I understand that if a participant appears to be in physical distress, staff will **call 911 first and emergency contacts second.** Primary care partners **must** provide a copy of a POLST (Physician Orders for Life-Sustaining Treatment) to be kept available at our facility if a DNR (Do Not Resuscitate) order is in place. Amy's Place cannot guarantee that POLSTS will be available to or followed by EMS. Amy's Place staff/volunteers are not required to obtain or maintain current CPR certification.

Elopement Policy Initials:_____

I understand that if the person receiving care leaves our premises, Amy's place will **first contact mall security, then the police, and then the emergency contacts/care partner.** This is to prioritise the participants' safety and locate them as quickly as possible.

Unscheduled Pick-Up Policy, Initials:_____

I acknowledge that occasionally, incidents occur, such as unexpected illness, hygiene issues, or extreme behavioral responses, which compromise the member's comfort/dignity while they are with us. Also, some circumstances may require the program to close for the day, such as a power outage, sudden severe weather, regional emergency, or building evacuation etc. In such situations, you may need to be prepared to pick up the member as soon as possible. Care partner must provide a phone number on our emergency contact sheet (see page 6)

Attendance Policy, Initials: ____

I will notify a staff member as soon as possible if the member will be late, leave early, or cannot attend on a scheduled day. Consistency is beneficial to the members and helpful in keeping the club running smoothly. Try to arrange appointments on days not scheduled to attend. Members must be accompanied to and from our space by a care partner. **Program staff are not responsible for escorting members to or from Amy's Place at drop-off or pick-up times.**

Meal Policy, Initials:_____

I understand a snack is offered each day, and adherence to special diets cannot be guaranteed. **If a special diet is required, the primary care partner must provide it** and discuss any dietary needs with staff at enrollment. Please do not rely on club snacks as a replacement for a meaningful, scheduled meal at home.

Cell Phone/Tablet Policy, Initials:_____

I agree with the statement: If cell phone or tablet use is triggering anxiety or distracting a member or other club members from participating in group activities, program staff may approach the primary care partner to arrange a creative plan to modify access to the device.

Scope of Practice Policy, Initials:_____

I understand that Amy's Place Respite Care is a social and recreational club. **It is not a caregiving service, adult day care, or medical program.** We offer social, cognitive, and physical opportunities for engagement by promoting a consistent small group relationship dynamic and accessible activities for ease of participation. We supervise, cue, redirect, model, simplify choices/directions, and de-escalate/stimulate as needed. **Participants must be able to reasonably perform basic activities of daily living, such as using the bathroom and moving short distances without hands-on intervention from our staff and volunteers. Participants must also be willing to engage with staff/volunteers/fellow participants most of the time, even if passively.** The goal of our respite is to facilitate a social group environment, facilitated by staff and sustained by our participants.

Medication Policy, Initials:_____

I (the care partner) and my person receiving care understand that members who require medication during program hours must be able to self-administer. **Program staff cannot give or measure medications, assist by reminding the member, or open a bottle.** It is recommended that members not visit during times they need to take medication. **Staff are not allowed to work with medication in any way**. **Please notify staff if members are carrying or expected to take medications.** (see next page)

Allergy/sensitivity disclosure, Initials:_____

If my person receiving care has an allergy or food sensitivity, I will communicate that with Amy's Place staff as well as put it in writing below. I also acknowledge that Amy's Place cannot guarantee 100% compliance with the information provided.

Allergies / Sensitivities:

_____

_____

_____

_____

Will the Participant Need to Take Medications at the Program?

Yes_____ No_____

If the participant will need to take medication during our program, please fill out the information below.

Name of Medication, Dose, and Frequency	Reason for Medication	Month/Year Began	Physician

Client (Caregiver) Surveys

Please fill out this brief survey to help us collect some information for our grants. (if you like)

https://redcap.link/CDRI-Evaluation-Client