

# Caring *for residents with* ALZHEIMER'S *and related dementias.*



## Resident Identification

Male  Female

NAME ..... AGE ..... RACE .....

ADDRESS ..... HEIGHT ..... WEIGHT .....

PHONE 1 ..... PHONE 2 ..... HAIR COLOR ..... EYE COLOR .....

**Speaks English**  Yes  No If no, what language? .....

**Behavioral challenges**  None  At times  Frequently  Other .....

## Family Contacts (in order of contact)

**1** NAME / RELATION .....

PHONE 1 ..... PHONE 2 .....

**2** NAME / RELATION .....

PHONE 1 ..... PHONE 2 .....

**3** NAME / RELATION .....

PHONE 1 ..... PHONE 2 .....

## Prescription Medications

Name	Dose	Times per day
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

## Physicians

**1** NAME .....

ADDRESS .....

CITY ..... ST ..... ZIP .....

PHONE .....

**2** NAME .....

ADDRESS .....

CITY ..... ST ..... ZIP .....

PHONE .....

## Illnesses/Diagnoses

.....

.....

.....

.....

## Allergies/Special Medical Needs

.....

.....

.....

.....