

## Specialized care checklist and journal

When there are several individuals caring for your family members with special needs, it is important to keep the lines of communication open.

This can be accomplished by using a journal. One family has used a journal with specific questions and categories and found it very helpful. Please feel free to keep the lines of communication open by using this document. It saves time and reduces stress for the family and caregiver.

Feel free to use this and modify it as needed.

### Personal Information:

Client Name: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Alternate contact for emergencies: \_\_\_\_\_

Child, youth or adult name: \_\_\_\_\_

Doctor: \_\_\_\_\_

Clinic and phone number. \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Current symptoms \_\_\_\_\_

Allergies \_\_\_\_\_ History of Seizures? \_\_\_\_\_

General emotional state of the child, youth or adult? \_\_\_\_\_ good \_\_\_\_\_ fair \_\_\_\_\_ poor  
Explain what interaction can be used to help understand the individual more clearly?

\_\_\_\_\_  
\_\_\_\_\_

Able to communicate needs? \_\_\_\_\_yes \_\_\_\_\_no

Cultural or religious needs? Please explain:

### Personal routines and habits:

Favorite distractions and likes:

\_\_\_\_\_

Dislikes: \_\_\_\_\_

Fears: \_\_\_\_\_

**Meals and snacks: List times, preferences and special instructions. Is the food served in a special way, is the person independent when eating, special family routines, traditions and preparations. Are there meal restrictions re: health, personal, cultural or religious.**

Breakfast:

Snack:

Lunch:

Snack:

Supper:

Snack:

**Bathroom routine:** \_\_\_\_\_ able to assist themselves; \_\_\_\_\_ needs assistance  
**Bathing and showering:** \_\_\_\_\_ able to assist themselves; \_\_\_\_\_ needs assistance. Requires specialized equipment?  
Describe the assistance required and how often.

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**Bedtime routine:** List times for: \_\_\_\_\_ naps \_\_\_\_\_ bedtimes  
Describe the assistance and routine for bedtime and naptime to assist make this a comfortable time for the child, youth or adult.  
Describe any special concerns for bedtime or naptime the caregiver should be aware of?

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How often to change bedding? Instructions for appropriate bedding required?

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**Medications:**

Name \_\_\_\_\_

Dose: \_\_\_\_\_

Time to be given: \_\_\_\_\_

Special instructions: \_\_\_\_\_

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Signature to administer: \_\_\_\_\_

**Medical equipment and maintenance:**

**Appointments:**

**Medical: need requisition; written documentation; insurance documentation \_\_\_\_\_ yes  
\_\_\_\_\_no \_\_\_\_\_ provided**

Doctor Name:

Location and Name of facility:

Time:

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**Dental: need written documentation or insurance information \_\_\_\_\_yes \_\_\_\_\_no \_\_\_\_\_  
provided**

Dentist Name:

Location and Name of facility:

Time:

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**Lab: need requisition or written documentation \_\_\_\_\_yes \_\_\_\_\_no \_\_\_\_\_  
provided**

Procedures to be completed:

Name and location of Lab:

Time:

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**Other: hair, physical therapy, personal, business**

Name of Person:

Name and location of facility:

Time:

Purpose:

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**Emergency preparedness:**

Family emergency contact numbers:

Name of alternates:

Address:

Phone number and cell phone number:

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Name of alternates:

Address:

Phone number and cell phone number:

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Return home on:

Family is gone from \_\_\_\_\_ to \_\_\_\_\_

Location:

Contact numbers:

Phone:            cell:

**A brief history of the family members ie: siblings, parents**

**Anyone who should not have access to the client:**