Alzheimers New Zealand

My Emergency Support Plan

Emergency Services 111

Healthline 0800 611 116

General Information about me:		
Name		
My Age/Date of birth		
Language	I speak I understand	
My GP/ Medical Practice		
My Current Support Providers		
My usual main carer/support persons details	Name Relationship Date of Birth NHI (if known)	
My Family Contacts	Name Relationship Contact Details Name	

	Relationship Contact Details	
My Needs Assessment Coordinator (NASC)	Name: Contact Details	
My Other Support Services Provider (e.g. day programme, personal/domestic care provider)	Name of Provider Contact Details:	
Alzheimers Organisation Details	Name of service provider Contact Details	
Other people who could be called upon in an emergency to provide my short-term support (e.g family/whanāu, neighbour, friend)	Name Relationship Contact Details Name Relationship Contact Details Name	

	Relationship Contact Details	
My legal and related information		
My Lawyers Details (if relevant)	Name/ Business name Contact Details	
Advanced Care Plan/ Advanced Directive	I have one. It is kept	Yes / No (circle whichever appropriate) Location: (Where it can be found)
My Enduring Power of Attorney	Financial Welfare -activated? Location of papers	Yes/ No (circle whichever appropriate) Yes/ No (circle whichever appropriate) Yes/No
Other information if known	NZ Superannuation Number	

My Health-Related Information		
My Medical Information	Allergies	State:
	Hearing	Good / Hard of Hearing/ I Wear aids (circle if apply)
	Vision	Good/ not good/I wear glasses (circle if apply)
	Toileting	I am self- toileting/ incontinent/ I use incontinent products (circle if apply)
	Mobility	I am Independent/I use an aid (provide details), I need assistance (describe)
	I Wear an ID bracelet, tracking device etc.?	Details
	My mental health and wellbeing	I have a history of depression/anxiety/ psychosis/another mental health issue (cross out and/or provide more information)

	I have a previous history of. (cross out if don't apply)	Stroke Heart disease High BP Falls Bleeding disorder Diabetes – if so any details about medication and blood testing should be provided Other (state)
Medications	The pharmacy I get my medications from is	
Medications	Those I take regularly (attach a pharmacy list if it is available)	
	Medications that I take on occasions e.g. for pain, gout	(List and give reason for taking)

My Cultural and Spiritual Preferences		
	Religion and special religious practices	
	Cultural practices that are important to continue	
	Other	
My Daily Routines and Personal Choices		
Morning Routines	My usual breakfast time My breakfast preferences – food and drink My morning tea preferences	

Drink Choices	Cold drinks	**I prefer (state)**
	Hot drinks	Tea/ coffee (circle preferences) Milk/sugar
Bathing	Type	I prefer Shower/ Bath (circle preference)
	Time	I prefer Morning/night/other (circle preference)
	Frequency	Daily/ other
Dressing	I need assistance	Yes/ No (circle) Preferences
Mobility/ Walking/activity	I am independent/ I need to be accompanied- give details	
Daily Activities	Details of what I like to do during the day e.g. TV, walk, gardening, puzzles etc.	
Lunch	My preferred time and preferences	
Afternoon tea	My preferred time and preferences	

Evening Meal	My preferred time and preferences	
Supper time and preferences	My preferred time and preferences	
Food Dislikes	Foods I do not like	
Bedtime routines	The time I prefer to go to bed and my preferred night-time routine	
	My usual night-time patterns (e.g. I settle quickly, I wake/get up in night,	
Other general information about me		
	Activities I enjoy e.g. TV, reading	

	magazines, music (type),	
	My clothing and grooming preferences:	
	Other things that will make a difference to making me feel well and secure	