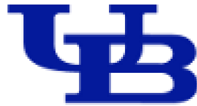

University at Buffalo
The State University of New York

Center of Excellence for Alzheimer's Disease WNY

100 High Street, E2-253 • Buffalo, NY 14203 • (716) 859-7498

Plan of Care

Name: ___________________________ **DOB:** __________ **New** ____ **Follow up** ____ **Date:** _________

Caregiver: ____________________ **Contact Information:** ___________________ **HIPPA up to Date:** ___

Diagnosis: ____

☐ MCI ☐ Mild ☐ Moderate ☐ Severe ☐ NA/UNK

What is your current living situation?

☐ Alone ☐ W/Spouse/Significant Other ☐ W/Family Member: ______________
☐ Adult Home/Group Home ☐ RC/AL/SNF (Memory Care) ☐ Other: _________________________

What county do you reside in? ___________________________ **Insurance:** _____________________________________

Current Services /Areas of Need

What **services** are currently in place? ☐ NA

☐ Adult Day Program: _____________ ☐ Support Group (s) ☐ Counseling
☐ Long Term Care Insurance Benefits ☐ Transportation: ________________ ☐ Meals on Wheels
☐ Legal: HCP/POA/Guardianship ☐ Nursing/HHA/Companion Care ☐ Respite
☐ Social Services: __________________ ☐ Other: ________________________ ☐ Other: _________________________

What are the current **areas of need**? ☐ NA

☐ Adult Day Program ☐ Support Group (s) ☐ Counseling: ____________________
☐ Access Long Term Care Benefits ☐ Transportation/Driving ☐ Safety Plan/Supervision
☐ Legal/Financial* ☐ Social Services: __________________ ☐ Medication Management
☐ Assistance with ADL's/IADL's* ☐ Behavior Management* ☐ RC/AL/SNF (Memory Care)
☐ Respite ☐ Nursing/HHA/Companion Care ☐ Caregiver Burnout
☐ Apply for Disability: ______________ ☐ Medical Alert Bracelet ☐ Other: _________________________

What type of **behaviors** are being seen? ☐ NA

☐ Aggression & Anger ☐ Anxiety ☐ Depression
☐ Hallucination ☐ Increased Memory Loss ☐ Repetition

☐ Sleep Issues: _________________
☐ Sundowning
☐ Suspicion
☐ Agitation
☐ Confusion
☐ Delusions
☐ Wandering
☐ Abusive
☐ Other: _______________________

When are the **behaviors** occurring? ☐ NA

☐ Morning
☐ Afternoon/Sundowning
☐ Evening
☐ Transition or Trigger points
☐ Overnight
☐ Other: ________________________

What **techniques**, have been put in place that are working to deal with any of the behaviors? What hasn't worked? ☐ NA

____

____

Are there **legal/financial** areas of need? ☐ NA

☐ Health Care Proxy
☐ Power of Attorney
☐ Guardianship
☐ Financial Planning
☐ Eldercare Attorneys
☐ Estate Planning

Is assistance required with any **ADL's or IADL's**? ☐ NA

☐ Communication
☐ Cooking
☐ Eating
☐ Incontinence
☐ Dressing
☐ Bathing
☐ Grooming
☐ Medication Management
☐ Driving
☐ Housekeeping
☐ Finances
☐ Other: _______________________

Additional Patient/Care Partners Areas of Concerns:

Patient Identified Areas of Need: ☐ NA

____

____

Care Partner Identified Areas of Need: ☐ NA

____

____

____

Referrals

Referrals given to the family on the following ☐ NA

☐ Alzheimer's Association (WNYACC)
☐ Office for the Aging (WNYACC)
☐ Catholic Charities (WNYACC)
☐ Respite
☐ Adult Day Programs
☐ Behavior Management
☐ Support Group (s)/Counseling
☐ Geriatric Case Manager
☐ Legal/Financial Services: __________
☐ RC/AL/SNF (Memory Care)
☐ Disability (SSI/SSDI/Short/Long)
☐ Supervision/Safety Plan
☐ Transportation
☐ VA Services
☐ Meals on Wheels
☐ Hospice
☐ Nursing/HHA/Companion Care
☐ Medical Alert Bracelet/Lifeline
☐ Interested in Clinical Trials
☐ Other: _______________________
☐ Other: _______________________

Additional Referral Notes:

Follow-up Goals/Recommendations: ☐ NA

Action Taken: ☐ NA

If information is being sent, who should it be sent to?

Person Completing Plan of Care

Signature **Date**