Australian Government

# Emergency Care Plan

Information for Carers

## Carer

Name______________________________________________

Relationship to person requiring care___________________________

Address____________________________________________

Contact Home:______________________ Work:________________________

Mobile:______________________

## Person Requiring Care

Name________________________________ Age___________

Relationship to person requiring care___________________________

Address____________________________________________

Contact Home:__________________________ Work:______________________

Mobile: ________________________

## Emergency Contacts

Name ____________________________________________

Relationship/Organisation__________________________________

Contact Home:_________________________ Work:_______________________

Mobile: ________________________

Name______________________________________________

Relationship/Organisation__________________________________

Contact Home:______________________ Work: _________________________

Mobile:________________________

Name______________________________________________

Relationship/Organisation__________________________________

Contact Home:_________________________ Work:_______________________

Mobile:________________________

# Health Information

***Details about the person I care for***

Person's illness or disability ______________________________________________

________________________________________________________________

Doctor Name______________________________________________________

Address__________________________________________________________

Telephone________________________________________________________

Medicare Number__________________________________________________

Health Insurance Fund Name of Fund____________________________________

Membership Number______________________________

Telephone______________________________________

Ambulance Fund/Registration Number____________________________________

Medic–Alert Number_________________________________________________

Description of care need_____________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

# Care Required

The person I am caring for needs:

☐ Meals only

☐ Regular visits only

☐ Full-time care – mobile, no personal care required

☐ Full-time care – mobile, supervision of toileting and showering required

☐ Full-time care – mobile, assistance with toileting, showering/bathing required

☐ Full-time care – assistance with lifting/transferring, toileting and showering/bathing required

☐ Other____________________________________________________

## Care required – continued

Supervision________________________________________________

Toileting – When___________________________________________

___________________________________________________________

___________________________________________________________

Showering/Bathing – When___________________________________

___________________________________________________________

Equipment used_____________________________________________

Number of people required__________________________________

Other______________________________________________________

Lifting/Transferring – When_________________________________

___________________________________________________________

Equipment used_____________________________________________

Number of people required__________________________________

Other _____________________________________________________

Diet_______________________________________________________

___________________________________________________________

___________________________________________________________

Other _____________________________________________________

## Regular Medication

| Name of Medication | Dosage | Special Instructions |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Allergies___________________________________________________

___________________________________________________________

___________________________________________________________

## Regular Home and Community Care Services

*Please advise if care arrangements change*

Organisation_______________________________________________

Service Provided____________________________________________

Contact Name______________________________________________

Telephone_________________________________________________

Organisation_______________________________________________

Service Provided____________________________________________

Contact Name______________________________________________

Telephone_________________________________________________

Organisation_______________________________________________

Service Provided____________________________________________

Contact Name______________________________________________

Telephone_________________________________________________

## Emergency Plan

In an emergency my contacts will________________________________

________________________________________________________

________________________________________________________

My emergency financial arrangements are__________________________

________________________________________________________

________________________________________________________

Name______________________________

Signature___________________________

Date_______________________________