



To whom it may concern

I support someone who is elderly, unwell, or disabled. If I become ill or die suddenly, please refer to this Plan to ensure uninterrupted care for the person I support.

MY NAME _____

ADDRESS _____

CITY/TOWN _____ PHONE _____

PLEASE NOTIFY THESE EMERGENCY CONTACTS IF I BECOME ILL OR DIE SUDDENLY

NAME _____ RELATIONSHIP _____

PHONE _____ MOBILE _____ EMAIL _____

NAME _____ RELATIONSHIP _____

PHONE _____ MOBILE _____ EMAIL _____

NAME _____ RELATIONSHIP _____

PHONE _____ MOBILE _____ EMAIL _____

MY DOCTOR _____ PHONE _____

MY SOLICITOR _____ PHONE _____

MY ACCOUNTANT _____ PHONE _____

COPIES OF MY IMPORTANT PAPERS (Will, Insurance Policies, Financial Documents, Birth Certificate, Passport etc) CAN BE FOUND IN THIS PLACE: _____

OR CONTACT _____ WHOSE DETAILS ARE LISTED ABOVE.

I HAVE A CURRENT WILL YES/NO MY IRD NUMBER _____

MY COMMUNITY SERVICES CARD NUMBER _____

IF I DIE, MY PREFERRED FUNERAL DIRECTOR OR SERVICE IS _____

PHONE _____ CITY/TOWN _____



Health information and care routines for the person I support

NAME OF PERSON REQUIRING SUPPORT _____

MY RELATIONSHIP TO THIS PERSON _____

THEIR AGE _____ ADDRESS _____

THEIR DOCTOR'S NAME _____ PHONE _____

THE PERSON I SUPPORT NEEDS REGULAR OR 24 HOUR ASSISTANCE YES/NO

DESCRIBE THE PERSON'S ILLNESS OR DISABILITY, AND DAILY CARE NEEDS (Attach extra notes if more space is needed)

THE PERSON I SUPPORT RECEIVES ASSISTANCE FROM CARE WORKERS OR OTHER VISITING HEALTH PROFESSIONALS

YES/NO SERVICES PROVIDED (How often, contact names and details) _____

PERSONAL CARE NEEDS (Circle all that apply)

BATHING/SHOWERING YES/NO IN THE AM/PM

DENTAL (Teeth/Denture Cleaning) YES/NO IN THE AM/PM

DRESSING YES/NO IN THE AM/PM

GROOMING (Hair, Nail Care etc) YES/NO IN THE AM/PM

ASSISTANCE IN THE BATHROOM YES/NO

BOWEL AND BLADDER CARE/PRODUCTS YES/NO

SPECIAL PREFERENCES OR DAILY ROUTINES (Describe) _____



Health information and care routines for the person I support continued ...

THE PERSON I SUPPORT REQUIRES ASSISTANCE WITH LIFTING/TRANSFERRING/MOBILITY YES/NO

EQUIPMENT USED, DAILY ROUTINES AND PREFERENCES (Attach extra notes if required)

FOOD AND DIETARY PREFERENCES, COFFEE/TEA ETC, FOOD ALLERGIES (Attach extra notes if required)

DRESSING AND GROOMING PREFERENCES, FAVOURITE CLOTHING, TOILETRIES, HAIR STYLES ETC (Attach extra notes if required)

OTHER PREFERENCES AND GENERAL CARE NEEDS OR ROUTINES (Attach extra notes if needed)

IMPORTANT! PLEASE ALSO REVIEW THE ATTACHED MEDICATION CARE PLAN FOR DOSAGES AND ROUTINES.



This Emergency Care Plan is designed for family carers who provide regular or 24 hour support for an elderly, ill, or disabled family member or friend.

If you become ill or die suddenly, having an up to date Emergency Care Plan will ensure uninterrupted care for the person you support.

Give copies of this Plan to at least one other member of your family or to a close friend, and/or to your GP, home support worker, or others who should know what to do if you are suddenly unable to continue caring.

When you and the person you support travel away from home, take a copy of your Emergency Care Plan with you, along with a completed Medications Plan. Also, keep a copy of your Emergency Carer Card in your wallet, handbag, or attach it to your key ring. If something happens to you, the Card will alert others that the person you support needs help too.

These tools are designed to give carers peace of mind.

If you cannot continue caring for whatever reason, others can quickly step in to help the person you support.

Carers NZ's suite of Care Planning Tools include:

- Emergency Care Plan
- Medications Plan
- Emergency Carer Card
- Important Papers Checklist

The Tools are free and can be downloaded at www.carers.net.nz

Or, request free print copies by phoning 0800 777 797.

Review the information in these documents regularly, and complete new ones if the information changes significantly.