AGING RESOURCES of Central Iowa
The Experts on Aging

CAREGIVER CUES

(515) 255-1310 ❖ (800) 747-5352

Care Receiver's Name: _____

Address: _____

City, State, Zip: _____

Phone Number: (_____) _____ - _____ Date of Birth: (M/D/Y) _____

Social Security Number: _____ - _____ - _____ Medicare Number: _____

Medicaid Number: (if applicable) _____

Supplemental Health Insurance Company: _____

Policy Number: _____

Primary Doctor: _____

Address: _____

City/St/Zip: _____

Phone: (____) _____ - _____

Physical/Mental impairments identified: _____ _____

_____

_____

_____

Allergies: _____

Support Network: (Agencies, others assisting the older person)

Name: _____ Phone: (_____) _____ - _____

Name: _____ Phone: (_____) _____ - _____

Name: _____ Phone: (_____) _____ - _____

Name: _____ Phone: (_____) _____ - _____

PRESCRIPTION AND OVER-THE-COUNTER DRUGS:
(All medications the older person is taking)

Pharmacy Name: ________________________________ Phone: (_____) ______ - ___________
Medication: ____
Dosage: __________________ Times Daily: _________________ for: ______________________

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Dosage: __________________ Times Daily: _________________ for: ______________________

Medication: ____
Dosage: __________________ Times Daily: _________________ for: ______________________

Pharmacy Name: ________________________________ Phone: (_____) ______ - ___________
Medication: ____
Dosage: __________________ Times Daily: _________________ for: ______________________

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Pharmacy Name: ________________________________ Phone: (_____) ______ - ___________
Medication: ____
Dosage: __________________ Times Daily: _________________ for: ______________________

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Medication: ____
Dosage: __________________ Times Daily: _________________ for: ______________________

Pharmacy Name: ________________________________ Phone: (_____) ______ - ___________
Medication: ____
Dosage: __________________ Times Daily: _________________ for: ______________________

Medication: ____
Dosage: __________________ Times Daily: _________________ for: ______________________

(Make extra copies for future "Med" changes)

Income Summary:

Income:	$ _____	Pension:	$ _____
Social Security:	$ _____	Dividends, Interest:	$ _____
Supplemental Security:	$ _____	Other Income:	$ _____
	Monthly Total	$ _____	

Assets Summary:

Bank Name: _____

Checking: Acct. # _____ $ _____
Savings Acct. # _____ $ _____
CD's _____
Stocks/Bonds _____
Trust Fund _____
Safe Deposit Box _____

Insurance Company Name: _____

Life: Acct. # _____ $ _____
Burial: Acct. # _____ $ _____

Total Worth: $ _____

Medical Power of Attorney:

Name: _____ Date Appointed_____
Alternate Power of Attorney_____
Hospital (file) Yes _____ No _____
Doctor (primary) Yes _____ No _____
Doctor (specialist) Yes _____ No _____
Caregiver (self or other primary caregiver) Yes _____ No _____

Financial Power of Attorney:

Name: _____
Address: _____
City/State/Zip: _____
Phone :(____) _____ - _____ Appointed Date_____

Journal

This may be used to record questions/concerns, doctor appointments, any event important to the well-being of the elder person's physical, mental, or social condition.

Date: _____

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Date: _____

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