MassMutual SpecialCare℠

Our Letter of Intent for our Loved One

The Letter of Intent

As part of the special needs planning process, you should complete a Letter of Intent. Although this is not a legally binding document, it can help ensure that future caregivers understand your wishes for your loved one with special needs. It will also allow the caregiver to more quickly learn how to deliver the very best care possible.

You should include as much detail as possible in your Letter of Intent. Draw upon what you know about your dependent through your observations and when appropriate, through discussions with him/her. Document what you have learned and update the information regularly and stored in a readily available location.

The following pages are not meant to be exhaustive, and they do not cover every detail that may be important to your letter. Every person has different needs, and everyone has different wishes for their loved ones. This outline is meant only as a guide to get you started.

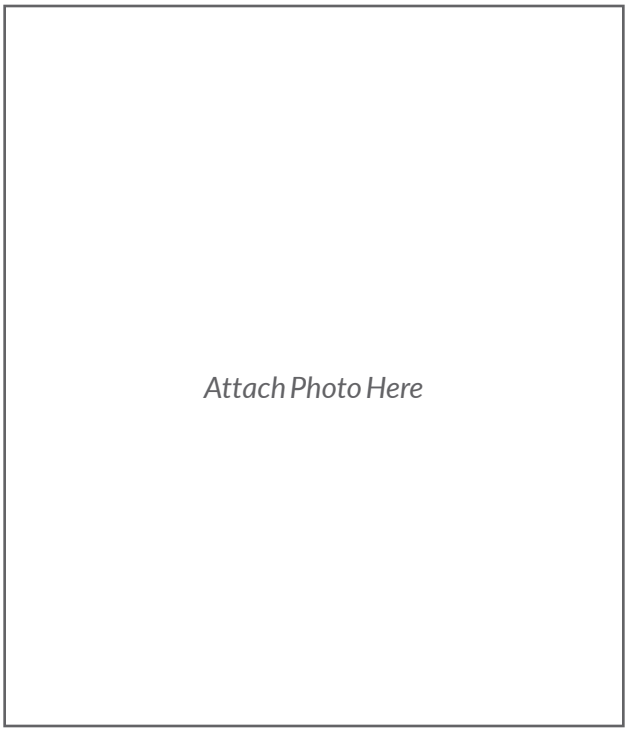
TABLE OF CONTENTS

This Letter of Intent is to share information about our loved one with special needs

_____

(special needs dependent's name)

and my/our wishes for his/her future.



PREPARED BY:_____ DATE: _____

SIGNATURE: _____

Relationship to Special Needs Dependent: _____

INFORMATION ABOUT OUR LOVED ONE WITH SPECIAL NEEDS

Contact Information

Date Last Updated: _____

Full Name: _____ Nickname: _____

Blood Type: _____ Date of Birth: _____

Race: _____ U.S. Citizen: ☐ Yes ☐ No

Ancestry: _____ Gender: _____

Home Phone: _____ Languages Spoken: _____

Religion: _____ Cell Phone: (_____) _____ - _____

Email: _____ Work Phone: (_____) _____ - _____

Full Address: _____ Employer: _____

Marital Status: ☐ Single ☐ Married Spouse/Partner's Name: _____

☐ Divorced ☐ Domestic Partner

Social Media

Date Last Updated: _____

List Type *(i.e. email, Facebook, etc.)*	Should account be monitored?	Account User Name	Account Password	Comments
_____	☐ Yes ☐ No	_____	_____	_____
_____	☐ Yes ☐ No	_____	_____	_____
_____	☐ Yes ☐ No	_____	_____	_____
_____	☐ Yes ☐ No	_____	_____	_____

Height / Weight / Clothing Sizes

Date Last Updated: _____

Height: _____ Weight: _____

Shirt Size: _____ Pants Size: _____ Shoe Size: _____

☒ **Items to Avoid** *(i.e. colors, fabrics, etc):* _____

Nutrition*

***IMPORTANT:** **See Food Allergies, if applicable, under the "Allergies" Section in this booklet**

Date Last Updated: _____

✓ Food Likes: _____

☒ Foods to Avoid: _____

DAILY LIVING

Daily Living Skills

(Describe current skill level and where assistance is needed)

Date Last Updated: _____

	Needs Assistance	Details
Bathing:	☐ Yes ☐ No	_____
Cooking:	☐ Yes ☐ No	_____
Dressing:	☐ Yes ☐ No	_____
Eating:	☐ Yes ☐ No	_____
Finances:	☐ Yes ☐ No	_____
Toileting:	☐ Yes ☐ No	_____
Traveling:	☐ Yes ☐ No	_____

Daily Routines

Date Last Updated: _____

Is an instructional video attached *(i.e. CD, DVD, flash drive, etc)*? ☐ Yes ☐ No

WEEKDAYS:

Mornings: _____

Afternoons: _____

Evenings: _____

WEEKENDS:

Mornings: _____

Afternoons: _____

Evenings: _____

RECREATIONAL PREFERENCES

Recreational Preferences:

Date Last Updated: _____

Current Hobbies: _____

Favorite Recreational Activities: _____

Vacation Preferences: _____

PERSONAL PREFERENCES

Personal Preferences:

Date Last Updated: _____

Favorite Things *(pets, people, toys, etc)*: _____

Social *(strengths, weaknesses, & preferences)*: _____

Triggers/Upsetting Things: _____

Antidotes/Soothing Things: _____

INFORMATION ABOUT BIRTH PARENTS

Birth Father

Date Last Updated: _____

Birth Father's Full Name: _____ Date of Birth: _____

Blood Type: _____ U.S. Citizen: ☐ Yes ☐ No

Ancestry: _____ Languages Spoken: _____

Religion: _____ Race: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Email: _____ Work Phone: (_____) _____ - _____

Marital Status: ☐ Single ☐ Married Employer: _____

☐ Divorced ☐ Domestic Partner Spouse/Partner's Name: _____

Full Address: _____

Significant Medical History: _____

Birth Mother

Date Last Updated: _____

Birth Mother's Full Name: _____ Date of Birth: _____

Blood Type: _____ U.S. Citizen: ☐ Yes ☐ No

Ancestry: _____ Languages Spoken: _____

Religion: _____ Race: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Email: _____ Work Phone: (_____) _____ - _____

Marital Status: ☐ Single ☐ Married Employer: _____

☐ Divorced ☐ Domestic Partner Spouse/Partner's Name: _____

Full Address: _____

Significant Medical History: _____

INFORMATION ABOUT SIBLINGS

Sibling

Date Last Updated: _____

Sibling Full Name: _____

Sibling Type: ☐ Traditional sibling *(same mother and father)*
☐ Half sibling *(share either same mother or father)*
☐ Stepsibling *(not biologically related but parents are married/domestic partners)*
☐ Adopted

Date of Birth: _____ U.S. Citizen: ☐ Yes ☐ No

Blood Type: _____ Gender: _____

Home Phone: (_____) _____ - _____ Email: _____

Cell Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Marital Status: ☐ Single ☐ Married Spouse/Partner's Name: _____

☐ Divorced ☐ Domestic Partner

Full Address: _____

Sibling

Date Last Updated: _____

Sibling Full Name: _____

Sibling Type:
- ☐ Traditional sibling *(same mother and father)*
- ☐ Half sibling *(share either same mother or father)*
- ☐ Stepsibling *(not biologically related but parents are married/domestic partners)*
- ☐ Adopted

Date of Birth: _____ U.S. Citizen: ☐ Yes ☐ No

Blood Type: _____ Gender: _____

Home Phone: (_____) _____ - _____ Email: _____

Cell Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Marital Status: ☐ Single ☐ Married Spouse/Partner's Name: _____

☐ Divorced ☐ Domestic Partner

Full Address: _____

Sibling

Date Last Updated: _____

Sibling Full Name: _____

Sibling Type:
- ☐ Traditional sibling *(same mother and father)*
- ☐ Half sibling *(share either same mother or father)*
- ☐ Stepsibling *(not biologically related but parents are married/domestic partners)*
- ☐ Adopted

Date of Birth: _____ U.S. Citizen: ☐ Yes ☐ No

Blood Type: _____ Gender: _____

Home Phone: (_____) _____ - _____ Email: _____

Cell Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Marital Status: ☐ Single ☐ Married Spouse/Partner's Name: _____

☐ Divorced ☐ Domestic Partner

Full Address: _____

Sibling

Date Last Updated: _____

Sibling Full Name: _____

Sibling Type:
- ☐ Traditional sibling *(same mother and father)*
- ☐ Half sibling *(share either same mother or father)*
- ☐ Stepsibling *(not biologically related but parents are married/domestic partners)*
- ☐ Adopted

Date of Birth: _____ U.S. Citizen: ☐ Yes ☐ No

Blood Type: _____ Gender: _____

Home Phone: (_____) _____ - _____ Email: _____

Cell Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Marital Status: ☐ Single ☐ Married Spouse/Partner's Name: _____

☐ Divorced ☐ Domestic Partner

Full Address: _____

INFORMATION ABOUT THE CAREGIVERS

Caregiver(S)

(if other than birth parents)

Date Last Updated: _____

Caregiver Full Name: _____ Date of Birth: _____

Blood Type: _____ U.S. Citizen: ☐ Yes ☐ No

Ancestry: _____ Languages Spoken: _____

Religion: _____ Race: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Email: _____ Work Phone: (_____) _____ - _____

Marital Status: ☐ Single ☐ Married Employer: _____

☐ Divorced ☐ Domestic Partner Spouse/Partner's Name: _____

Full Address: _____

Caregiver(S)

(if other than birth parents)

Date Last Updated: _____

Caregiver Full Name: _____ Date of Birth: _____

Blood Type: _____ U.S. Citizen: ☐ Yes ☐ No

Ancestry: _____ Languages Spoken: _____

Religion: _____ Race: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Email: _____ Work Phone: (_____) _____ - _____

Marital Status: ☐ Single ☐ Married Employer: _____

☐ Divorced ☐ Domestic Partner Spouse/Partner's Name: _____

Full Address: _____

PREFERENCES

Caregiver(S) and/or Dependent's Preferences

Date Last Updated: _____

Dating: _____

Sex: _____

Birth Control: _____

Marriage: _____

Religion: _____

Work: _____

Future Care: _____

Future Education: _____

Funeral/Burial: _____

HOUSING ARRANGEMENTS

Past

Date Last Updated: _____

Present

Date Last Updated: _____

Future

Date Last Updated: _____

INSURANCE INFORMATION

Insurance Information

Date Last Updated: _____

	Insurance Company	Policyholder	Policy #	Insurance Phone
Primary Medical:				(___) ___ - ___
Secondary Medical:				(___) ___ - ___
Dental:				(___) ___ - ___
Vision:				(___) ___ - ___
Other: _____				(___) ___ - ___

GOVERNMENT BENEFITS

Government Benefits

List government benefits your special needs dependent receives.
(i.e. Social Security Income (SSI), Social Security Disability Income (SSDI), etc)

Date Last Updated: _____

Government Benefit Type : _____

Case #: _____

Frequency: _____ Amount: $ _____

Contact Name: _____ Contact Phone: (_____) _____ - _____

Contact Email: _____

Comments: _____

Date Last Updated: _____

Government Benefit Type : _____

Case #: _____

Frequency: _____ Amount: $ _____

Contact Name: _____ Contact Phone: (_____) _____ - _____

Contact Email: _____

Comments: _____

State Caseworker

Date Last Updated: _____

Case #: _____

Caseworker Name: _____ Caseworker Phone: (_____) _____ - _____

Caseworker Email: _____

Comments: _____

COMMUNITY SERVICES

Community Services

List benefits/services your special needs dependent receives from the community.

Date Last Updated: _____

Name: _____

Description: _____

Dates of Service: ____ /____ /____ to ____ /____ /____

Case #: _____

Date Last Updated: _____

Name: _____

Description: _____

Dates of Service: ____ /____ /____ to ____ /____ /____

Case #: _____

EDUCATIONAL INFORMATION

Current School

Date Last Updated: _____

School Name: _____ Current Grade: _____

Full Address: _____

Contact Name: _____ Contact Phone: (_____) _____ - _____

Contact Email: _____

School Start Time: _____ School End Time: _____

Transportation to/from School: _____

Transportation Contact Name & Phone: _____

Pick-up Time/Location *(include special instructions)*: _____

Drop-off Time/Location *(include special instructions)*: _____

Our loved one currently has: ☐ 504 Plan
☐ IEP (Individual Education Plan)
☐ IFSP (Individual Family Service Plan)

Where is the Plan stored? _____

Other comments: _____

EDUCATIONAL SUPPORT TEAM

Current School – Child Support Team

(i.e. Child Study Team, Student Study Team, Student Intervention Team, Student Success Team, etc.)

Date Last Updated: _____

Contact Name: _____ Contact Phone: (_____) _____ - _____

Contact Email: _____

Role / Title: _____

Contact Name: _____ Contact Phone: (_____) _____ - _____

Contact Email: _____

Role / Title: _____

Contact Name: _____ Contact Phone: (_____) _____ - _____

Contact Email: _____

Role / Title: _____

Contact Name: _____ Contact Phone: (_____) _____ - _____

Contact Email: _____

Role / Title: _____

Contact Name: _____ Contact Phone: (_____) _____ - _____

Contact Email: _____

Role / Title: _____

Contact Name: _____ Contact Phone: (_____) _____ - _____

Contact Email: _____

Role / Title: _____

EDUCATIONAL HISTORY

Previous School(S)

Date Last Updated: _____

School Name: _____ Last Grade Attended: _____

Full Address: _____

Contact Name: _____ Contact Phone: (_____) _____ - _____

Contact Email: _____

Attended from: ____ /____ /____ to ____ /____ /____

School Name: _____ Last Grade Attended: _____

Full Address: _____

Contact Name: _____ Contact Phone: (_____) _____ - _____

Contact Email: _____

Attended from: ____ /____ /____ to ____ /____ /____

School Name: _____ Last Grade Attended: _____

Full Address: _____

Contact Name: _____ Contact Phone: (_____) _____ - _____

Contact Email: _____

Attended from: ____ /____ /____ to ____ /____ /____

School Name: _____ Last Grade Attended: _____

Full Address: _____

Contact Name: _____ Contact Phone: (_____) _____ - _____

Contact Email: _____

Attended from: ____ /____ /____ to ____ /____ /____

Comments about Schools, Teachers, Aides, etc.

_____

CONTACTS – Family/Friends

Family / Friends

Date Last Updated: _____

Family/Friend Full Name: _____

Relationship to your dependent: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____ Email: _____

Full Address: _____

Date Last Updated: _____

Family/Friend Full Name: _____

Relationship to your dependent: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____ Email: _____

Full Address: _____

Date Last Updated: ________________

Family/Friend Full Name: ______________________________

Relationship to your dependent: ______________________________

Home Phone: (________) ________ - ________ Work Phone: (________) ________ - ________

Cell Phone: (________) ________ - ________ Email: ______________________________

Full Address: ______________________________

Date Last Updated: ________________

Family/Friend Full Name: ______________________________

Relationship to your dependent: ______________________________

Home Phone: (________) ________ - ________ Work Phone: (________) ________ - ________

Cell Phone: (________) ________ - ________ Email: ______________________________

Full Address: ______________________________

Date Last Updated: ________________

Family/Friend Full Name: ______________________________

Relationship to your dependent: ______________________________

Home Phone: (________) ________ - ________ Work Phone: (________) ________ - ________

Cell Phone: (________) ________ - ________ Email: ______________________________

Full Address: ______________________________

Date Last Updated: ________________

Family/Friend Full Name: ______________________________

Relationship to your dependent: ______________________________

Home Phone: (________) ________ - ________ Work Phone: (________) ________ - ________

Cell Phone: (________) ________ - ________ Email: ______________________________

Full Address: ______________________________

Date Last Updated: ________________

Family/Friend Full Name: ______________________________

Relationship to your dependent: ______________________________

Home Phone: (________) ________ - ________ Work Phone: (________) ________ - ________

Cell Phone: (________) ________ - ________ Email: ______________________________

Full Address: ______________________________

CONTACTS – Physicians

Physicians

Date Last Updated: ________________

Physician's Full Name: ______________________________ Specialty: ______________________________

Phone: (______) ________ - ________ Date of Last Visit: ______________________________

Email: ____

Full Address: ____

Comments: ____

Date Last Updated: ________________

Physician's Full Name: ______________________________ Specialty: ______________________________

Phone: (______) ________ - ________ Date of Last Visit: ______________________________

Email: ____

Full Address: ____

Comments: ____

Date Last Updated: ________________

Physician's Full Name: ______________________________ Specialty: ______________________________

Phone: (______) ________ - ________ Date of Last Visit: ______________________________

Email: ____

Full Address: ____

Comments: ____

Date Last Updated: ________________

Physician's Full Name: ______________________________ Specialty: ______________________________

Phone: (______) ________ - ________ Date of Last Visit: ______________________________

Email: ____

Full Address: ____

Comments: ____

Date Last Updated: _____

Physician's Full Name: _____ Specialty: _____

Phone: (_____) _____ - _____ Date of Last Visit: _____

Email: _____

Full Address: _____

Comments: _____

Date Last Updated: _____

Physician's Full Name: _____ Specialty: _____

Phone: (_____) _____ - _____ Date of Last Visit: _____

Email: _____

Full Address: _____

Comments: _____

Date Last Updated: _____

Physician's Full Name: _____ Specialty: _____

Phone: (_____) _____ - _____ Date of Last Visit: _____

Email: _____

Full Address: _____

Comments: _____

PREFERENCES – Physicians

Preferences with Physicians

Date Last Updated: _____

☒ Physicians we recommend to avoid: _____

CONTACTS - Therapists

Therapists

Date Last Updated: ________________

Therapist's Full Name: ______________________________ Specialty: ______________________

Phone: (______) ________ - ________ Date of Last Visit: ______________________

Email: ____

Full Address: ____

Comments: ____

Date Last Updated: ________________

Therapist's Full Name: ______________________________ Specialty: ______________________

Phone: (______) ________ - ________ Date of Last Visit: ______________________

Email: ____

Full Address: ____

Comments: ____

Date Last Updated: ________________

Therapist's Full Name: ______________________________ Specialty: ______________________

Phone: (______) ________ - ________ Date of Last Visit: ______________________

Email: ____

Full Address: ____

Comments: ____

Date Last Updated: ________________

Therapist's Full Name: ______________________________ Specialty: ______________________

Phone: (______) ________ - ________ Date of Last Visit: ______________________

Email: ____

Full Address: ____

Comments: ____

Date Last Updated: _____

Therapist's Full Name: _____ Specialty: _____

Phone: (_____) _____ - _____ Date of Last Visit: _____

Email: _____

Full Address: _____

Comments: _____

Date Last Updated: _____

Therapist's Full Name: _____ Specialty: _____

Phone: (_____) _____ - _____ Date of Last Visit: _____

Email: _____

Full Address: _____

Comments: _____

Date Last Updated: _____

Therapist's Full Name: _____ Specialty: _____

Phone: (_____) _____ - _____ Date of Last Visit: _____

Email: _____

Full Address: _____

Comments: _____

PREFERENCES – Therapists

Preferences with Therapists

Date Last Updated: _____

☒ Therapists we recommend to avoid: _____

CONTACTS – Nurses

Nurses

Date Last Updated: ________________

Nurse's Full Name: ________________ Specialty: ________________

Phone: (______) ______ - ______ Date of Last Visit: ________________

Email: ________________

Full Address: ________________

Comments: ________________

Date Last Updated: ________________

Nurse's Full Name: ________________ Specialty: ________________

Phone: (______) ______ - ______ Date of Last Visit: ________________

Email: ________________

Full Address: ________________

Comments: ________________

Date Last Updated: ________________

Nurse's Full Name: ________________ Specialty: ________________

Phone: (______) ______ - ______ Date of Last Visit: ________________

Email: ________________

Full Address: ________________

Comments: ________________

Date Last Updated: ________________

Nurse's Full Name: ________________ Specialty: ________________

Phone: (______) ______ - ______ Date of Last Visit: ________________

Email: ________________

Full Address: ________________

Comments: ________________

Date Last Updated: _____

Nurse's Full Name: _____ Specialty: _____

Phone: (_____) _____ - _____ Date of Last Visit: _____

Email: _____

Full Address: _____

Comments: _____

Date Last Updated: _____

Nurse's Full Name: _____ Specialty: _____

Phone: (_____) _____ - _____ Date of Last Visit: _____

Email: _____

Full Address: _____

Comments: _____

Date Last Updated: _____

Nurse's Full Name: _____ Specialty: _____

Phone: (_____) _____ - _____ Date of Last Visit: _____

Email: _____

Full Address: _____

Comments: _____

PREFERENCES – Nurses

Preferences with Nurses

Date Last Updated: _____

☒ Nurses we recommend to avoid: _____

CONTACTS – Aides/Helpers

Aides / Helpers

Date Last Updated: ______________

Aide's/Helper's Full Name: ______________________ Specialty: ______________________

Phone: (______) ________ - ________ Date of Last Visit: ______________________

Email: ____

Full Address: ____

Comments: ____

Date Last Updated: ______________

Aide's/Helper's Full Name: ______________________ Specialty: ______________________

Phone: (______) ________ - ________ Date of Last Visit: ______________________

Email: ____

Full Address: ____

Comments: ____

Date Last Updated: ______________

Aide's/Helper's Full Name: ______________________ Specialty: ______________________

Phone: (______) ________ - ________ Date of Last Visit: ______________________

Email: ____

Full Address: ____

Comments: ____

Date Last Updated: ______________

Aide's/Helper's Full Name: ______________________ Specialty: ______________________

Phone: (______) ________ - ________ Date of Last Visit: ______________________

Email: ____

Full Address: ____

Comments: ____

PREFERENCES – Aides/Helpers

Preferences with Aides/Helpers

Date Last Updated: _____

☒ Aides/Helpers we recommend to avoid: _____

CONTACT – Vocational

Vocational

Date Last Updated: _____

Name: _____ Work Phone: (_____) _____ - _____

Full Address: _____

CONTACT – Pharmacy

Pharmacy - Local

Date Last Updated: _____

Name: _____ Work Phone: (_____) _____ - _____

Full Address: _____

Pharmacy - Mail Service

Date Last Updated: _____

Name: _____ Work Phone: (_____) _____ - _____

Full Address: _____

Email: _____

CONTACT – Preferred Hospital

Hospital - Preferred

Date Last Updated: _____

Name: _____ Work Phone: (_____) _____ - _____

Full Address: _____

CONTACT – Estate/Financial

Estate / Financial

Date Last Updated: _____

Current Guardians

Full Name: _____

Phone: (____) ____ - ____ Email: _____

Full Address: _____

Alternate Guardian

Full Name: _____

Phone: (____) ____ - ____ Email: _____

Full Address: _____

Trustee/Trust

Full Name: _____

Phone: (____) ____ - ____ Email: _____

Full Address: _____

Executor/Will

Full Name: _____

Phone: (____) ____ - ____ Email: _____

Full Address: _____

Power of Attorney

Full Name: _____

Phone: (____) ____ - ____ Email: _____

Full Address: _____

Healthcare Proxy

Full Name: _____

Phone: (____) ____ - ____ Email: _____

Full Address: _____

Financial Advisor

Full Name: _____

Phone: (____) ____ - ____ Email: _____

Full Address: _____

Special Needs Attorney

Full Name: _____

Phone: (____) ____ - ____ Email: _____

Full Address: _____

IMPORTANT LEGAL DOCUMENTS

	Established	Date Established	Storage Location	Date Last Updated
Will	☐ Yes ☐ No	___/___/___	_____	___/___/___
Living Will	☐ Yes ☐ No	___/___/___	_____	___/___/___
Durable Powers of Attorney	☐ Yes ☐ No	___/___/___	_____	___/___/___
Guardianship	☐ Yes ☐ No	___/___/___	_____	___/___/___
Special Needs Trust	☐ Yes ☐ No	___/___/___	_____	___/___/___

OTHER IMPORTANT DOCUMENTS

Other Important Documents

List any other important reference documentation/records that are not listed in this Letter of Intent, i.e. other binders or folders you maintain.

Date Last Updated: _____

Description	Storage Location *(i.e. lockbox, safe, etc.)*	Comments
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL EQUIPMENT

Type & Cost of Medical Equipment Needs

(i.e. hearing aid, eyeglasses, wheelchair, etc)

Date Last Updated: _____

Type: _____ Brand: _____ Approx. Cost: $_____

Details *(i.e. size, color, etc.):* _____

Supplier Name: _____ Supplier Phone: (_____) _____ - _____

Type: _____ Brand: _____ Approx. Cost: $_____

Details *(i.e. size, color, etc.):* _____

Supplier Name: _____ Supplier Phone: (_____) _____ - _____

Type: ____________ Brand: ____________ Approx. Cost: $____________

Details *(i.e. size, color, etc.):* ____________

Supplier Name: ____________ Supplier Phone: (______) ______ - ______

Type: ____________ Brand: ____________ Approx. Cost: $____________

Details *(i.e. size, color, etc.):* ____________

Supplier Name: ____________ Supplier Phone: (______) ______ - ______

Type: ____________ Brand: ____________ Approx. Cost: $____________

Details *(i.e. size, color, etc.):* ____________

Supplier Name: ____________ Supplier Phone: (______) ______ - ______

Type: ____________ Brand: ____________ Approx. Cost: $____________

Details *(i.e. size, color, etc.):* ____________

Supplier Name: ____________ Supplier Phone: (______) ______ - ______

Type: ____________ Brand: ____________ Approx. Cost: $____________

Details *(i.e. size, color, etc.):* ____________

Supplier Name: ____________ Supplier Phone: (______) ______ - ______

BIRTH HISTORY

Birth History

Date of Birth: ____ /____ /____ Weight: ____________ Length: ____________

Time of Birth: ____ /____ /____ Place of Birth: ____________

Delivered by (Full Name): ____________

Birth Delivery Information: ____________

DIAGNOSES

Diagnoses

Date Last Updated: ____________________

Diagnosis: ______________________________ Date of diagnosed: ____/____/____

Diagnosed by: ______________________________

Tests performed and results *(include dates)*: ______________________________

Diagnosis definition: ______________________________

What does this diagnosis mean for our loved one? ______________________________

Diagnosis: ______________________________ Date of diagnosed: ____/____/____

Diagnosed by: ______________________________

Tests performed and results *(include dates)*: ______________________________

Diagnosis definition: ______________________________

What does this diagnosis mean for our loved one? ______________________________

Diagnosis: ______________________________ Date of diagnosed: ____/____/____

Diagnosed by: ______________________________

Tests performed and results *(include dates)*: ______________________________

Diagnosis definition: ______________________________

What does this diagnosis mean for our loved one? ______________________________

Diagnosis: ______________________________ Date of diagnosed: ____/____/____

Diagnosed by: ______________________________

Tests performed and results *(include dates)*: ______________________________

Diagnosis definition: ______________________________

What does this diagnosis mean for our loved one? ______________________________

MEDICAL HISTORY - Immunizations

Immunizations

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

Immunization: _____ Date: ____ / ____ / ____

MEDICAL HISTORY - Hospitalizations

Hospitalizations

Reason: _____

Location: _____ Date(s): _____

Results: _____

Reason: _____

Location: _____ Date(s): _____

Results: _____

Reason: _____

Location: _____ Date(s): _____

Results: _____

Reason: _____

Location: _____ Date(s): _____

Results: _____

Reason: _____

Location: _____ Date(s): _____

Results: _____

Reason: _____

Location: _____ Date(s): _____

Results: _____

Reason: _____

Location: _____ Date(s): _____

Results: _____

Reason: _____

Location: _____ Date(s): _____

Results: _____

MEDICAL HISTORY - Surgical Procedures

Surgical Procedures

Reason: _____

Location: _____ Date(s): _____

Results: _____

Reason: _____

Location: _____ Date(s): _____

Results: _____

Reason: _____

Location: _____ Date(s): _____

Results: _____

Reason: _____

Location: _____ Date(s): _____

Results: _____

Reason: _____

Location: _____ Date(s): _____

Results: _____

Reason: _____

Location: _____ Date(s): _____

Results: _____

Reason: _____

Location: _____ Date(s): _____

Results: _____

Reason: _____

Location: _____ Date(s): _____

Results: _____

ALLERGIES – Food

Food Allergies

Date Last Updated: _____

List Known Food Allergy: _____ Date: ___/___/___

Reaction Symptoms: _____

Testing: _____

Treatment: _____

List Known Food Allergy: _____ Date: ___/___/___

Reaction Symptoms: _____

Testing: _____

Treatment: _____

List Known Food Allergy: _____ Date: ___/___/___

Reaction Symptoms: _____

Testing: _____

Treatment: _____

List Known Food Allergy: _____ Date: ___/___/___

Reaction Symptoms: _____

Testing: _____

Treatment: _____

List Known Food Allergy: _____ Date: ___/___/___

Reaction Symptoms: _____

Testing: _____

Treatment: _____

ALLERGIES - Medications

Drug Allergies

Date Last Updated: _____

List Known Drug Allergy: _____ Date: ___/___/___

Reaction Symptoms: _____

Testing: _____

Treatment: _____

List Known Drug Allergy: _____ Date: ___/___/___

Reaction Symptoms: _____

Testing: _____

Treatment: _____

List Known Drug Allergy: _____ Date: ___/___/___

Reaction Symptoms: _____

Testing: _____

Treatment: _____

List Known Drug Allergy: _____ Date: ___/___/___

Reaction Symptoms: _____

Testing: _____

Treatment: _____

ALLERGIES - Environmental

Environmental Allergies

(i.e. seasonal, cleaning solutions, insect bites, etc)

Date Last Updated: _____

List Known Environmental Allergy: _____ Date: ___/___/___

Reaction Symptoms: _____

Testing: _____

Treatment: _____

List Known Environmental Allergy: _____ Date: ____ / ____ / ____

Reaction Symptoms: _____

Testing: _____

Treatment: _____

List Known Environmental Allergy: _____ Date: ____ / ____ / ____

Reaction Symptoms: _____

Testing: _____

Treatment: _____

List Known Environmental Allergy: _____ Date: ____ / ____ / ____

Reaction Symptoms: _____

Testing: _____

Treatment: _____

List Known Environmental Allergy: _____ Date: ____ / ____ / ____

Reaction Symptoms: _____

Testing: _____

Treatment: _____

ALLERGIES - Pets

Pet Allergies

Date Last Updated: _____

List Known Pet Allergy: _____ Date: ____ / ____ / ____

Reaction Symptoms: _____

Testing: _____

Treatment: _____

List Known Pet Allergy: _____ Date: ____ / ____ / ____

Reaction Symptoms: _____

Testing: _____

Treatment: _____

List Known Pet Allergy: _____ Date: ____ / ____ / ____

Reaction Symptoms: _____

Testing: _____

Treatment: _____

ALLERGIES - Other

(Other) Allergies

Date Last Updated: _____

List "Other" Known Allergy: _____ Date: ____ / ____ / ____

Reaction Symptoms: _____

Testing: _____

Treatment: _____

List "Other" Known Allergy: _____ Date: ____ / ____ / ____

Reaction Symptoms: _____

Testing: _____

Treatment: _____

List "Other" Known Allergy: _____ Date: ____ / ____ / ____

Reaction Symptoms: _____

Testing: _____

Treatment: _____

List "Other" Known Allergy: _____ Date: ____ / ____ / ____

Reaction Symptoms: _____

Testing: _____

Treatment: _____

Medical History - Medications

Medications

Date Last Updated: ______________

Medication Name: ______________________________ Currently Taking: ☐ Yes ☐ No

Dosage: ______________________________ Date Prescribed: ____ /____ /____

Reason: ______________________________

Prescribed by: ______________________________

Comments: ______________________________

Medication Name: ______________________________ Currently Taking: ☐ Yes ☐ No

Dosage: ______________________________ Date Prescribed: ____ /____ /____

Reason: ______________________________

Prescribed by: ______________________________

Comments: ______________________________

Medication Name: ______________________________ Currently Taking: ☐ Yes ☐ No

Dosage: ______________________________ Date Prescribed: ____ /____ /____

Reason: ______________________________

Prescribed by: ______________________________

Comments: ______________________________

Medication Name: ______________________________ Currently Taking: ☐ Yes ☐ No

Dosage: ______________________________ Date Prescribed: ____ /____ /____

Reason: ______________________________

Prescribed by: ______________________________

Comments: ______________________________

Medication Name: ______________________________ Currently Taking: ☐ Yes ☐ No

Dosage: ______________________________ Date Prescribed: ____ /____ /____

Reason: ______________________________

Prescribed by: ______________________________

Comments: ______________________________

Medication Name: ______________________________ Currently Taking: ☐ Yes ☐ No

Dosage: ______________________________ Date Prescribed: ____ /____ /____

Reason: ______________________________

Prescribed by: ______________________________

Comments: ______________________________

Medication Name: ______________________________ Currently Taking: ☐ Yes ☐ No

Dosage: ______________________________ Date Prescribed: ____ /____ /____

Reason: ______________________________

Prescribed by: ______________________________

Comments: ______________________________

Medication Name: ______________________________ Currently Taking: ☐ Yes ☐ No

Dosage: ______________________________ Date Prescribed: ____ /____ /____

Reason: ______________________________

Prescribed by: ______________________________

Comments: ______________________________

Medication Name: ______________________________ Currently Taking: ☐ Yes ☐ No

Dosage: ______________________________ Date Prescribed: ____ /____ /____

Reason: ______________________________

Prescribed by: ______________________________

Comments: ______________________________

Medication Name: ______________________________ Currently Taking: ☐ Yes ☐ No

Dosage: ______________________________ Date Prescribed: ____ /____ /____

Reason: ______________________________

Prescribed by: ______________________________

Comments: ______________________________

ADDITIONAL COMMENTS

Use this area to share any other thoughts or feelings about your loved one that would help to reflect the quality of care that you have provided for your special needs dependent.