



Information for Respite Care Service Providers: Addendum to TCARE® Assessment

CARE RECEIVER'S NAME		DATE
DATE OF BIRTH	PROVIDER ONE ID	
CAREGIVER'S NAME		CAREGIVER PHONE ()

1. List current prescribed medications including over the counter medications, supplements, and topicals. (Attach physician's order for prescribed medications.)

Yellow response area for item 1.

2. List any medications known to cause adverse or allergic reactions including the specific reactions to each medication listed.

Yellow response area for item 2.

3. Describe any food allergies, sensitivities, or special dietary needs including swallowing issues, consistency limits, or restrictions. (Attach physician's order for any specialized diet.)

Yellow response area for item 3.

4. List any environmental allergies such as pet, pollen, etc.

Yellow response area for item 4.

5. Describe recent medical history (chronic and current) including emergency department, hospital, nursing home placements and any surgery, treatments, etc. Also describe any precaution related to medical history such as weight bearing or positioning limitations / restrictions.

Yellow response area for item 5.

6. Describe any infection disease diagnoses / issues, symptoms, and related procedures for care / treatment (including tuberculosis).

Yellow response area for item 6.

7. Note any potential skin care needs and risks for skin issues.

Yellow response area for item 7.

8. List current medical diagnoses.

Yellow response area for item 8.

9. Describe known behaviors or symptoms (having occurred during last five years) that may cause concern or require special care including history of substance abuse, harming self / others / property, wandering, and supervision needs related to smoking. Include triggers for behaviors and usual successful interventions for noted behaviors.

Yellow response area for item 9.

10. Describe social, physical, and emotional strengths and needs.

Yellow response area for item 10.

11. Note any history of depression, anxiety, and/or mental health issues.

12. Note preferences / choices regarding daily life such as preferred foods, meal times, sleeping / nap times, activities, and daily routines.

13. Evacuation Capability Levels (select one)

- Independent: Individual is physically and mentally capable of safely getting out of the home without the assistance of another individual or the use of mobility aids. The individual is getting out of the house without assistance from another individual or mobility aids.
- Assistance Required: Individual is not physically or mentally capable of getting out of the house without assistance from another individual or mobility aids.