Your input to transitioning your loved one into a health care community is very valuable. The Daily Care Snapshot will assist staff by building on your knowledge and experience. The more information you provide, the better others can get to know your loved one’s needs and preferences.  

- Thank you. 

I. *Give a brief introduction of the person you have cared for* - life accomplishments, key relationships with family/friends, and what your role as a caregiver has been and will be.

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

(Attach a favorite photo here)
II. Describe regular activities, hobbies, and current abilities. Include the level of assistance needed for each activity. For example, he/she can complete activities independently; needs help getting started; or requires monitoring. Add additional strengths. Use additional pages as needed.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

III. Describe any concerns or needs in the following areas, and the helpful steps taken in the past. Include specific examples of behaviors, such as refusing to shower; grinding teeth; or at risk of choking. For helpful interventions, include medical/community resources, i.e. psychiatry, religious affiliation, therapy, as well as successful behavioral/communication approaches. Use additional pages as needed.

SELF CARE (Examples: Dressing, eating, walking, personal hygiene, toileting)

Concerns/Needs__________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Helpful Interventions_____________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Medication(s) Prescribed for Each Concern____________________________________
______________________________________________________________________________
INTERPERSONAL (Examples: Repetitive habits, fixed stare, one-word responses, incorrect use of the words “yes” and “no”, sleep disturbance, overwhelmed easily)

Concerns/Needs
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________

Helpful Interventions
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________

Medication(s) Prescribed for Each Concern/Need
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________

SAFETY (Examples: Wandering, falls, puts too much food into mouth without swallowing, eating non-food items)

Concerns/Needs
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________

Helpful Interventions
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________

Medication(s) Prescribed for Each Concern/Need
________________________________________________________________________________________________________________________
IV. Other comments or experiences to share. ________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Name of Client/Resident________________________________________________________
Name of Person Sharing Information___________________________________________
Relationship to Client/Resident ________________________________________________
Date completed __________________________________________________________________