MassMutual | SpecialCare
a special needs program developed by MassMutual

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.

Attach Photo Here

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: _____

Date of Birth: _____

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

Race: _____ Gender: _____

Ancestry: _____ Languages Spoken: _____

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

Religion: _____ Work Phone: ( ) - _____

Email: _____ Employer: _____

Full Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner

Spouse/ Partner's Name: _____

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: _____

U.S. Citizen: ☐ Yes ☐ No

Blood Type: _____ Languages Spoken: _____

Ancestry: _____ Race: _____

Religion: _____ Cell Phone: ( ) -

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

Email: _____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ 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: _____

U.S. Citizen: ☐ Yes ☐ No

Blood Type: _____ Languages Spoken: _____

Ancestry: _____ Race: _____

Religion: _____ Cell Phone: ( ) -

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

Email: _____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ 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 ☐ Divorced ☐ Domestic Partner

Spouse/ Partner's Name: _____

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 ☐ Divorced ☐ Domestic Partner

Spouse/ Partner's Name: _____

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 ☐ Divorced ☐ Domestic Partner

Spouse/ Partner's Name: _____

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 ☐ Divorced ☐ Domestic Partner

Spouse/ Partner's Name: _____

Full Address: _____

INFORMATION ABOUT THE CAREGIVERS

CAREGIVER(S)

(if other than birth parents)

Date Last Updated: _____

Caregiver Full Name: _____ Date of Birth: _____

U.S. Citizen: ☐ Yes ☐ No

Blood Type: _____ Languages Spoken: _____

Ancestry: _____ Race: _____

Religion: _____ Cell Phone: ( ) -

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

Email: _____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ 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: _____

U.S. Citizen: ☐ Yes ☐ No

Blood Type: _____ Languages Spoken: _____

Ancestry: _____ Race: _____

Religion: _____ Cell Phone: ( ) -

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

Email: _____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ 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

PRESENT

Date Last Updated: _____

_____

PAST

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

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)

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.

_____

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: _____

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: _____

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: _____

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: ____________________

CONTACTS – Vocational

VOCATIONAL

Date Last Updated: _____

Name: _____ Phone: ( ) -

Full Address: _____

CONTACTS – Pharmacy

PHARMACY – LOCAL

Date Last Updated: _____

Name: _____ Phone: ( ) -

Full Address: _____

PHARMACY – MAIL SERVICE

Date Last Updated: _____

Name: _____ Phone: ( ) -

Full Address: _____

Email: _____

CONTACTS – Preferred Hospital

HOSPITAL – PREFERRED

Date Last Updated: _____

Name: _____ Phone: ( ) -

Full Address: _____

ESTATE / FINANCIAL

Date Last Updated: _____

Current Guardian 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 *(i.e. lockbox, safe, etc.)*	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

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 diagnosed: / /
Diagnosed by: ____
Tests performed and results *(include dates)*: ______________________________________
Diagnosis definition: ____
What does this diagnosis mean for our loved one? ______________________________________

Diagnosis: ______________________________________ Date diagnosed: / /
Diagnosed by: ____
Tests performed and results *(include dates)*: ______________________________________
Diagnosis definition: ____
What does this diagnosis mean for our loved one? ______________________________________

Diagnosis: ______________________________________ Date diagnosed: / /
Diagnosed by: ____
Tests performed and results *(include dates)*: ______________________________________
Diagnosis definition: ____
What does this diagnosis mean for our loved one? ______________________________________

Diagnosis: ______________________________________ Date diagnosed: / /
Diagnosed by: ____
Tests performed and results *(include dates)*: ______________________________________
Diagnosis definition: ____
What does this diagnosis mean for our loved one? ______________________________________

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: ___/___/___

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Immunization: _____ Date: ___/___/___

Immunization: _____ Date: ___/___/___

Immunization: _____ Date: ___/___/___

Immunization: _____ Date: ___/___/___

Immunization: _____ Date: ___/___/___

Immunization: _____ Date: ___/___/___

Immunization: _____ Date: ___/___/___

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: _____

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: _____

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: _____

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: _____

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: _____

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: _____

(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: _____

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: ____

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.