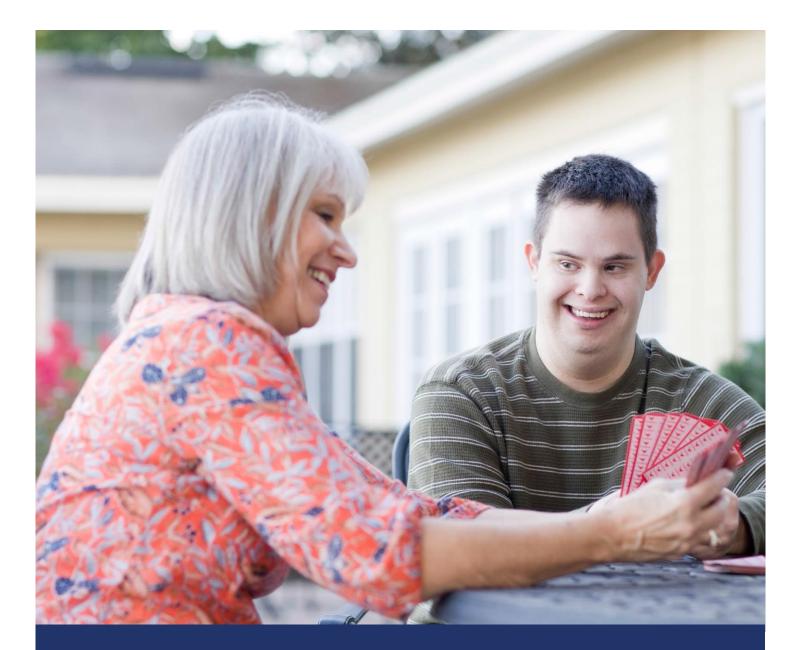
....MassMutual SpecialCare



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.

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	30

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 Speci	al Needs Dependent:		

INFORMATION ABOUT OUR LOVED ONE WITH SPECIAL NEEDS

CONTACT INFORM	VIATION		
		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	Spouse/ Partner's Name:	
SOCIAL MEDIA			
		Date Last Updated:	
List Type (i.e. ei Facebook <u>, etc.)</u>		Name Account Password Comments	
FUCEDOOK, <u>ELC.J</u>			
	Yes No		
HEIGHT / WEIGHT	T / CLOTHING SIZES		
		Date Last Updated:	
Height:	Weight:		
Chint Cine.		ize: Shoe Size:	
Shirt Size: Pants Size: Shoe Size: Shoe Size: Shoe Size: Shoe Size:			
NUTRITION*			
*IMPORTANT: See F	ood Allergies, if applicable, under the "Al	lergies" Section in this booklet	
		Date Last Updated:	
✓ Food Likes:			
🗵 Foods to Ave			

		DAILY LIVING	
ILY LIVING S	KILLS		
(Describe c	urrent skill level and	where assistance is needed)	Date Last Updated:
	Needs Assistance	<u>Details</u>	
Bathing:	Yes No		
Cooking:	Yes No		
Dressing:	Yes No		
Eating:	Yes No		
Finances:	Yes No		
Toileting:	🗌 Yes 🗌 No		
Traveling:	🗌 Yes 🗌 No		
	ES		
		Da	ate Last Updated:
<u>ls an instru</u>	ctional video attache	ed (i.e. CD, DVD, flash drive, etc)?	Yes No
WEEKDAYS	<u>:</u>		
Mornings:			
Afternoons	:		
Evenings:			
WEEKENDS	<u>:</u>		
Mornings:			
Afternoons	:		
Evenings:			
		RECREATIONAL PREFERE	NCES
ECREATIONAI	L PREFERENCES:		· · · · · · · · · · · · · · · · · · ·
		Do	ate Last Updated:
Current Ho			
	creational Activities	:	
Vacation Pr	references:		
		PERSONAL PREFERENC	ES
ERSONAL PRE	FERENCES:		
		Da	ate Last Updated:
Favorite Th	ings (pets, people, to	oys, etc):	
	ngths, weaknesses, a	& preferences):	
	osetting Things:		
Antidotes/S	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:	
Significant Medical History:	Date Last Updated:
Significant Medical History:	
Significant Medical History:	Date Last Updated: Date of Birth: U.S. Citizen: Yes
Significant Medical History:	Date Last Updated: Date of Birth: U.S. Citizen: Yes No Languages Spoken: Date
Significant Medical History:	Date Last Updated: Date of Birth: U.S. Citizen: Yes No Languages Spoken: Date
Significant Medical History:	Date Last Updated: Date of Birth: U.S. Citizen: Yes No Languages Spoken: Race:
Significant Medical History:	Date Last Updated: Date of Birth: U.S. Citizen: Yes No Languages Spoken: Race: Cell Phone: (
Significant Medical History: H MOTHER Birth Mother's Full Name: Blood Type: Ancestry: Religion: Home Phone: _() -	Date Last Updated: Date of Birth: U.S. Citizen: Yes No Languages Spoken: Race: Cell Phone:) Work Phone:) Eventorem
Significant Medical History:	Date Last Updated:

	INFORMATION ABO	PUT SIBLINGS
		Date Last Updated:
Sibling Full Nam	ne:	
Sibling Type:	 Traditional sibling (same mother and j Half sibling (share either same mother Stepsibling (not biologically related budyen 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 Sibling Full Nam	ne:	Date Last Updated:
Sibling Type:	 Traditional sibling (same mother and j Half sibling (share either same mother Stepsibling (not biologically related budget) Adopted 	
Date of Birth:		U.S. Citizen: 🗌 Yes 🗌 No
Blood Type:		Gender:
Home Phone:	() -	Email:
Cell Phone:	<u> () </u>	Work Phone: _() -
Marital Status:	Single Married Domestic Partner	Spouse/ Partner's Name:
Full Address:		

SIBLING

Marital Status: Single Married Spouse/ Divorced Domestic Partner Partner's Name: Full Address: SIBLING Sibling Full Name:	Sibling Type:	Traditional sibling <i>(same mother and fa</i> Half sibling <i>(share either same mother c</i> Stepsibling <i>(not biologically related but</i>	or father)
Half sibling (share either same mother or father) Stepsibling (not biologically related but parents are married/domestic partner Adopted Date of Birth: Home Phone: ()) - Cell Phone: ()) - Marital Status: Single Divorced Domestic Partner Full Address: Sibling Full Name:		 Half sibling (share either same mother of Stepsibling (not biologically related but 	or father)
Blood Type: Gender: Home Phone:) Cell Phone:) Cell Phone:) Single Married Divorced Domestic Partner Full Address: SIBLING Sibling Full Name:	Date of Birth:		
Home Phone: (Cell Phone: (() Marital Status: Single Divorced Domestic Partner Full Address: SIBLING Sibling Full Name:			U.S. Citizen: 🗌 Yes 🗌 No
Cell Phone: (() Marital Status: Single Divorced Domestic Partner Full Address: SIBLING Sibling Full Name:	Blood Type:		Gender:
Marital Status: Single Married Spouse/ Divorced Domestic Partner Partner's Name: Full Address: SIBLING Sibling Full Name:	Home Phone:	() -	Email:
Marital Status: Divorced Divorced Domestic Partner Partner's Name: Sibling Full Name:	Cell Phone:	() -	Work Phone: () -
SIBLING Date Last Updated: Sibling Full Name:	Marital Status:		•
Date Last Updated: Sibling Full Name:	Full Address:		
	BLING		Date Last Updated:
	Sibling Full Nan	le:	
Sibling Type: Half sibling <i>(share either same mother or father)</i> Stepsibling <i>(not biologically related but parents are married/domestic partne</i> Adopted			
Date of Birth: U.S. Citizen: Yes No	Sibling Type:	Stepsibling (not biologically related but	or father)
Blood Type: Gender:		 Half sibling (share either same mother of Stepsibling (not biologically related but Adopted 	or father) parents are married/domestic partners)
Home Phone: () - Email:	Date of Birth:	 Half sibling (share either same mother of Stepsibling (not biologically related but Adopted 	or father) parents are married/domestic partners) U.S. Citizen: Yes No
	Date of Birth: Blood Type:	 Half sibling (share either same mother of Stepsibling (not biologically related but Adopted 	or father) parents are married/domestic partners) U.S. Citizen: Yes No Gender:
Cell Phone: () - Work Phone: () -	Date of Birth: Blood Type:	 Half sibling (share either same mother of Stepsibling (not biologically related but Adopted 	or father) parents are married/domestic partners) U.S. Citizen: Yes No Gender:
Cell Phone: (- Work Phone: () - Marital Status: Single Married Spouse/ Spouse/ Partner's Name:	Date of Birth: Blood Type: Home Phone: Cell Phone:	☐ Half sibling (share either same mother of	or father) : parents are married/domestic partners) U.S. Citizen: Yes No Gender: Email: Work Phone: () - Spouse/

Г

_

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	Spouse/ Partner's Name:
Full Address:	
REGIVER(S)	
	Date Last Updated:
REGIVER(S)	
(if other than birth parents)	Date Last Updated:
REGIVER(S) (if other than birth parents)	Date Last Updated: Date of Birth: U.S. Citizen:
REGIVER(S) (if other than birth parents) Caregiver Full Name:	Date Last Updated: Date of Birth: U.S. Citizen: Yes No Languages Spoken: Date of
REGIVER(S) (if other than birth parents) Caregiver Full Name: Blood Type:	Date Last Updated: Date of Birth: U.S. Citizen: Yes No Languages Spoken: Date of
REGIVER(S) (if other than birth parents) Caregiver Full Name: Blood Type: Ancestry: Religion:	Date Last Updated: Date of Birth: U.S. Citizen: Yes No Languages Spoken: Race:
REGIVER(S) (if other than birth parents) Caregiver Full Name: Blood Type: Ancestry: Religion:	Date Last Updated:
REGIVER(S) (if other than birth parents) Caregiver Full Name: Blood Type: Ancestry: Religion: Home Phone: () Email:	Date Last Updated:

PREFERENCES

CAREGIVER(S) AND/OR DEPENDENT'S PREFERENCES

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

COMMUNITY SERVICES

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

					Date Last Updated:
Name:					
Description:					
Dates of Service:	/	/	to	/	/
Case #:					
				Г	
					Date Last Updated:
Name:					Date Last Updated:
Name:					Date Last Updated:
	/	/	to	/	Date Last Updated:

EDUCATIONAL INFORMATION

CU	DD	ENI	ТС	СЦ	\mathbf{n}	
U	KK	EIN	1 3	СП	00	L

Date Last Updated:

School Name:			Curre	nt Grad	e:
Full Address:					
Contact Name:		Contact Phone:	()	-
Contact Email:					
School Start Time:	Sch	nool End Time:			
Transportation to/from school:					
Transportation Contact Name 8	& 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 P	lan)			
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: () -
Role / Title:	
Contact Name:	Contact Phone: _ (_)
Contact Name:	Contact Phone: () -
Contact Email:	
Role / Title:	
Contact Name:	Contact Phone: _()
Contact Email:	
Contact Name:	Contact Phone: _()
Contact Email:	
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.

Date Last Updated:				contacts – Fa	mily/Friends
Family/Friend Full Name: Relationship to your dependent: Home Phone:	IILY / FRIENDS	5			
Relationship to your dependent:					Date Last Updated:
Home Phone:	Family/Friend	Full N	ame:		
Cell Phone: () - Email:	Relationship to	your	dependent		
Full Address:	Home Phone:	() -	W	/ork Phone:
Family/Friend Full Name:		(
Relationship to your dependent: Home Phone: () - Cell Phone: () - Full Address:					Date Last Updated:
Relationship to your dependent: Home Phone: () - Cell Phone: () - Full Address:	Family/Friend	Full N	ame:		
Cell Phone: () - Email: Full Address:	Relationship to	your	dependent		
Full Address:	Home Phone:	() -	W	/ork Phone:
Date Last Updated:	Cell Phone:	() -	E	mail:
Family/Friend Full Name: Relationship to your dependent: Home Phone: () Home Phone: () Cell Phone: () Gell Phone: () Full Address: Email: Full Address:	Full Address:				
Family/Friend Full Name: Relationship to your dependent: Home Phone: () Home Phone: () Cell Phone: () Gell Phone: () Full Address: Email: Full Address:					
Family/Friend Full Name: Relationship to your dependent: Home Phone: () Home Phone: () Cell Phone: () Gell Phone: () Full Address: Email: Full Address:					Date Last Updated:
Relationship to your dependent:	Fourily /Fuiend	F.			
Home Phone: () - Work Phone: () - Cell Phone: () - Email:	-				
Cell Phone: () - Email: Full Address:	-	-			
Full Address:					maile
Date Last Updated:		(
Family/Friend Full Name:	i un ruuress.				
Family/Friend Full Name:					
Relationship to your dependent:					Date Last Updated:
Home Phone: () - Work Phone: () - Cell Phone: () - Email:	Family/Friend	Full N	ame:		
Home Phone: () - Work Phone: () - Cell Phone: () - Email:	Relationship to	your	dependent		
Full Address: Date Last Updated: Family/Friend Full Name: Relationship to your dependent: Home Phone: () Work Phone: () -	Home Phone:	() -	W	/ork Phone:
Date Last Updated: Family/Friend Full Name: Relationship to your dependent: Home Phone:	Cell Phone:	() -	Ei	mail:
Family/Friend Full Name: Relationship to your dependent: Home Phone: () - Work Phone: ()	Full Address:				
Family/Friend Full Name: Relationship to your dependent: Home Phone: () - Work Phone: ()					
Family/Friend Full Name: Relationship to your dependent: Home Phone: () - Work Phone: ()					Date Last Updated:
Relationship to your dependent: Home Phone: () - Work Phone:	Eamily/Eriand		me:		· · · ·
Home Phone: () - Work Phone: () -	-				
	-	-	-		
		_\() -		

Full /	Address:
--------	----------

				Date Last Updated:
Family/Friend	Full N	ame:		
Relationship to	your	depend	lent:	
Home Phone:	()	-	Work Phone: () -
Cell Phone:	()	-	Email:
Full Address:				
				Date Last Updated:
Family/Friend	Full N	ame:		
Relationship to	your	depend	lent:	
Home Phone:	()	-	Work Phone: () -
Cell Phone:	()	-	Email:
Full Address:				

CONTACTS - Physicians

	Date Last Updated:
Physician's Full Name:	Specialty:
Phone: () -	
Freedile	
Full Addross	
	Date Last Updated:
Physician's Full Name:	Specialty:
Phone: () -	
Full Addrossy	
	Date Last Updated:
Physician's Full Name:	Specialty:
Phone: () -	
Email:	
Full Address:	
	Dete Lest Undeted
	Date Last Updated:
Physician's Full Name:	Specialty:
Phone: () -	Date of Last Visit:
Email:	
Full Address:	
Comments:	
	Date Last Updated:
	Specialty:
Physician's Full Name:	
Physician's Full Name: Phone:()	

	Date Last Updated:
Physician's Full Name:	Specialty:
Phone: () -	
Email:	
Full Address:	
	Date Last Updated:
Physician's Full Name:	Specialty:
Phone: () -	
- ·!	
Comments:	
	PREFERENCES – Physicians
EFERENCES WITH PHYSICIANS	
FERENCES WITH PHISICIANS	Date Last Updated:

Physicians we recommend to avoid:

CONTACTS - Therapists

APISTS	
	Date Last Updated:
Therapist's Full Name:	Specialty:
Phone: () -	
Email:	
Full Address:	
Comments:	
	Date Last Updated:
Therapist's Full Name:	Specialty:
Phone: <u>() -</u>	
Email:	
Full Addross:	
	Date Last Updated:
Therapist's Full Name:	Specialty:
Phone: () -	
Email:	
Full Address:	
Comments:	
	Date Last Updated:
Therapist's Full Name:	Specialty:
Phone: () -	
Email:	
Full Addross:	
Comments:	
	Date Last Updated:
Therapist's Full Name:	
Phone: () -	
Phone: () - Email:	

	Date Last Updated:
Therapist's Full Name:	Specialty:
Phone: _(
Email:	
Full Address:	
Comments:	
	Date Last Updated:
Therapist's Full Name:	Specialty:
Phone: () -	
Email:	
Full Address:	
Commentes	
	ERENCES – Therapists
PREFE	-NENCES - THEIRPISS

PREFERENCES WITH THERAPISTS

Date Last Updated:

Therapists we recommend to avoid:

CONTACTS – Nurses

ES	
	Date Last Updated:
Nurse's Full Name:	Specialty:
Phone: <u>() -</u>	
Email:	
Full Addross:	
	Date Last Updated:
Nurse's Full Name:	
Phone: <u>()</u> - Email:	
Eull Addrose:	
	Date Last Updated:
Nurse's Full Name:	Specialty:
Phone: () -	
Email:	
Full Addross:	
Comments:	
	Date Last Updated:
Nurse's Full Name:	Specialty:
Phone: () -	Date of Last Visit:
Email:	
Full Address:	
Commentation	
	Date Last Updated:
Nurse's Full Name:	
Phone: () -	Date of Last Visit:
Email:	
Full Address:	
Comments:	

Page 20 of 38

	Date Last Updated:
Nurse's Full Name:	Specialty:
Phone: () -	
Email:	
Full Address:	
Comments:	
	Date Last Updated:
Nurse's Full Name:	Specialty:
Phone: _() -	
Email:	
Full Address:	
PREF	ERENCES – Nurses
FERENCES WITH NURSES	
	Date Last Updated:
☑ Nurses we recommend to avoid:	·

CONTACTS – Aides/Helpers

Aide's/Helper's Full Name:	Specialty:
Phone: () -	
Email:	
Address:	
	Dete Leet Undeted
	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:	
Phone: () -	Date of Last Visit:
Email:	
	Date Last Updated:
Aide's/Helper's Full Name:	Specialty:
Phone: () -	
Email:	
Comments:	
PREFEREN	CES – Aides/Helpers
RENCES WITH AIDES/HELPERS	Date Last Updated:
⊠ Aides/Helpers we	

CONTACTS - Vocational

VOCATIONAL					
	Date Last Updated:				
Name:	Phone:	()	-	
	CONTACTS – Pharmacy				
PHARMACY – LOCAL					
	Date Last Updated:				
Name:	Phone:	()	-	
					_
PHARMACY – MAIL SERVICE					
	Date Last Updated:				
Name:				-	
Full Address:					_
					_
C	ONTACTS – Preferred Hospital				
HOSPITAL – PREFERRED	Date Last Updated:				7
	Phone:	()	-	_
					_

CONTACTS – Estate/Financial

ESTATE / FINANC			
			Date Last Updated:
		L	
Current Guardian	Full Name:		
) -	Email:
	Full Address:		
Alternate Guardian			
) -	
	Full Address:		
Trustee/Trust	Full Name:		
) -	Email:
	_		
Executor/Will	Full Name:		
	Phone: () -	Email:
	Full Address:		
Power of Attorney	Full Namo:		
Power of Attorney			Email:
) -	Email:
	Full Address:		
Healthcare Proxy	Full Name:		
) -	Email:
Financial Advisor	Full Name:		
	Phone: () -	Email:
	Full Address:		
Special Needs Attorn	ney Full Nam	e.	
	-	e:	
	Full Addr		

IMPORTANT LEGAL DOCUMENTS

	Established	Date Established	<u>Storage Location</u> (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.

	D	ate Last Updated:
Description	Storage Location (i.e. lockbox, safe, etc.)	<u>Comments</u>

	MEDICAL EQUIPME	ENT
YPE & COST OF MEDICAL EQUIPMEN		
.e. hearing aid, eyeglasses, wheelchair, etc)		Date Last Updated:
Timoi	Prandi	Approx Cost:
		Approx. Cost: \$
Details (<i>i.e. size, color, etc.</i>):		Supplier Phone: _() -
		Approx. Cost: \$
Supplier Name:		Supplier Phone: () -
Туре:	Brand:	Approx. Cost: \$
Details (<i>i.e. size, color, etc.</i>):		
		Supplier Phone: _() -
Туре:	Brand:	Approx. Cost: _\$
Details (i.e. size, color, etc.):		
		Supplier Phone: () -
Type:	Brand:	Approx. Cost: _\$
Detaile (i.e. size as les etc.)	· · · ·	
· · · · · · ·		Supplier Phone: _() -
Туре:	Brand:	Approx. Cost: \$
Supplier Name:		
· · ·		
Type:	Brandi	Approx. Cost: \$
Type: Details (<i>i.e. size, color, etc.)</i> :		
Supplier Name:		Supplier Phone: () -
Supplier Rulle.		

BIRTH HISTORY

BIRTH HISTORY

Date of Birth:	/	/	Weight:	Length:	
Time of Birth:			Place of Birth:		
Delivered by (Full I	Name):				
Birth Delivery Info	rmation:				

DIAGNOSES

	Date Last Updated:		
Diagnosis:	Date diagnosed:	/	/
Diagnosed hy:			
Tasts performed and results <i>(include dates)</i> :			
What does this diagnosis mean for our loved one?			
Diagnosis:	Date diagnosed:	/	/
Diagnosed by:			
Tests would and we wilt (include dates).			
What doos this diagnosis mean for our loved and			
Diagnosis:	Date diagnosed:	/	/
Diagnosed by:			
Taska wawfa waa ad awal waavilka (in ali ida daska ali			
Diagnosis:	Date diagnosed:	/	/
Diagnosod by:			
Tests performed and results <i>(include dates</i>):			
Diagnosis definition:			

MEDICAL HISTORY - Immunizations

IMMUNIZATIONS

Immunization:	
Immunization:	

Date: / Date: <td< th=""><th></th><th></th><th></th></td<>			
Date: / Date: <td< td=""><td>Date:</td><td>/</td><td>/</td></td<>	Date:	/	/
Date: / Date: <td< td=""><td>Date:</td><td>/</td><td>/</td></td<>	Date:	/	/
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MEDICAL HISTORY - Hospitalizations

HOSPITALIZATIONS

Reason:	
Location:	
Results:	
Reason:	
Location:	
Results:	
Reason:	
Location:	Date(s):
Results:	
Reason:	
Location:	
Results:	
Reason:	
Location:	
Results:	
Reason:	
Location:	Date(s):
Desulta	
Reason:	
Location:	$D_{abc}(a)$
Results:	
Reason:	
Location:	
Results:	

MEDICAL HISTORY - Surgical Procedures

SURGICAL PROCEDURES

Reason:	
Location:	Date(s):
Results:	
Reason:	
Location:	
Results:	
Reason:	
Location:	
Results:	
Reason:	
Location:	
Results:	
Reason:	
Location:	
Results:	
Reason:	()
Results:	
Reason:	
Reason:	
Results:	、,

ALLERGIES - Food

FOO	D AL	LERG	IES
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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: Beaction Symptoms:		/	/
Reaction Symptoms: Testing:			
Treatment:			
List Known Food Allergy:	Date:	/	/
Reaction Symptoms:			
Testing:			
Treatment:			

ALLERGIES - Medications

G ALLERGIES	
	Date Last Updated:
List Known Drug Allergy:	Date: / /
Reaction Symptoms:	
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:	
Taskiasi	
Treatment:	

ALLERGIES - Environmental

/IRONMENTAL ALLERGIES				
seasonal, cleaning solutions, insect bites, etc)	Date Last Updated	:		
List Known Environmental Allergy:	Date:	/	/	
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

ALLERGIES			
	Date Last Updated:		
List Known Pet Allergy:	Date:	/	/
Reaction Symptoms:			
List Known Pet Allergy:	Date:	/	/
-			
List Known Pet Allergy:	Date:	/	/
Tracture			

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

CATIONS			
	Date Last Updated:		
Medication Name:	Currently Taking:] Yes	Г
Dosage:		/	
Proscribod by:			
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Medication Name:	Currently Taking:	Yes	
Dosage:		/	/
Reason:			
Medication Name:	Currently Taking:] Yes	
Dosage:	Date Prescribed: /	/	/
Reason:			
Comments:			
	Currently Taking:	Yes	C
Dosage:		/	'
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Medication Name:	Currently Taking:	Yes	
Dosage:		/	'
Reason:			
Prescribed by:			
Comments:			
Medication Name:	Currently Taking:	Yes	
Dosage:		/	'
2			
Dressrihad by:			
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	Currently Taking:	_	C
Dosage:		/	1
Reason:		,	

Prescribed by:			
Comments:			
Medication Name:	Currently Taking:	🗌 Yes	🗌 No
Dosage:	Date Prescribed:	/	/
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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:		/	/
Reason:			
Drocorihod bu			
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.



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