**CARERS EMERGENCY PLAN**

Complete this form to provide information to help support your Cared for

person in the event of an emergency situation involving yourself.

Consider the most appropriate place(s) to leave copies of this ‘Carers Emergency

Plan e.g. with a neighbour, family member, a copy on your kitchen wall etc.

**CARER DETAILS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name:** |  | **Preferred name:** | |  |
| **Address:** |  | | | |
| **Telephone no.:** |  | **Date of Birth:** | |  |
| **Relationship to Cared for:** |  | | | |
| **General health:** |  | | | |
| **GP Surgery:** |  | **Telephone no.:** | |  |
| **Is Lasting Power of Attorney in place?** | **Health and Welfare** | | **Property and Financial Affairs** | |
| Yes / No (please delete) | | Yes / No (please delete) | |

**DETAILS OF THE CARED FOR PERSON**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Preferred name:** |  |
| **Address:** |  | | |
| **Telephone no.:** |  | **Date of Birth:** |  |
| **Gender:** |  | **Main language:** |  |
| **GP Surgery:** |  | **Telephone no.:** |  |
| **Health condition and/or disability:** | *Please include any issues with communication e.g. hearing aid, vision, speech, behaviour* | | |

**EMERGENCY CONTACTS**

|  |  |  |
| --- | --- | --- |
|  | **Primary Emergency Contact** | **Secondary Emergency Contact** |
| **Name:** |  |  |
| **Telephone no.:** |  |  |
| **Relationship to Cared for:** |  |  |

**DETAILS OF THE CARED FOR’S EXISTING SUPPORT**

|  |  |  |
| --- | --- | --- |
| **Who provides existing support for Cared for person?**  *This can include support from a care agency, GP, community nurse, friend, family etc.*  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Cared for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Cared for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Cared for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Cared for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Please describe the support currently in place:**  *Daily routine, waking up, washing, continence, meal times, activities, bed time, likes and dislikes* | | |
| **Please list prescribed medication(s) or detail the location of where an up-to-date list of medication(s) can be found - this is usually supplied by the Pharmacy with the medications:** | | |
|  | | |
| **When is medication(s) usually taken?** | *Consider time of day and frequency* | |
| **Location of medication:** | *Be as specific as possible i.e. right hand kitchen cupboard, above fridge* | |
| **Cared for allergies:** | *Identify all allergies i.e. medication, food, skin etc.* | |
| **Please describe any further information that you think would assist in helping to provide support for the person you care for:**  *Could they be supported to remain at home with support? How much support would they need? Would they require a temporary stay in a residential home?* | | |
| **Date plan completed:** | |  |

**Useful contact numbers in an emergency** *(i.e. for immediate, mid-term or long term support should the carer no longer be able to provide care):*

**Nottingham City Council, Health and Care Point: 0300 131 0300, Emergency Duty Team Out of Hours: 0115 876 1000**

**Nottinghamshire County Council Adult Services: 0300 500 80 80 option 1 then option 3**