

# The Senior Alliance<sup>TM</sup>

## Caregiver Binder

If lost, please return this binder to:

CONTACT INFORMATION	
NAME	
ADDRESS	
PHONE NUMBER	
EMAIL	

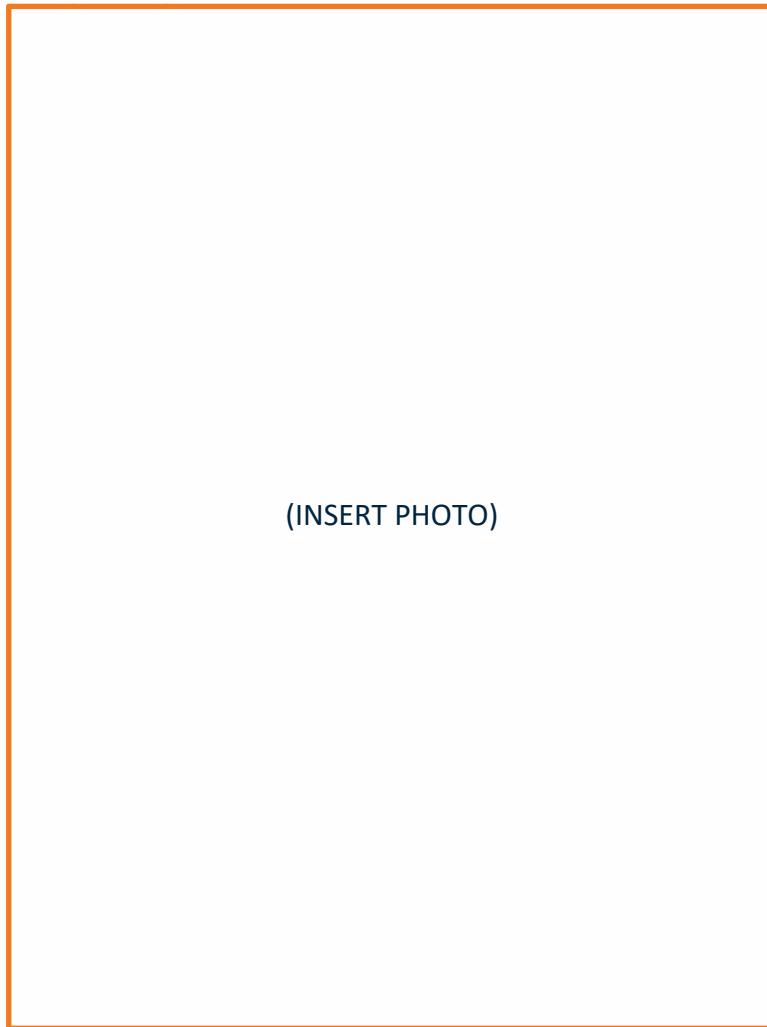
The Senior  
Alliance™  
**Caregiver Binder**



**PERSONAL INFORMATION**

# The Senior Alliance™

## Caregiver Binder



**How to best care for:**

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(Preferred name or nickname)

## PERSON-CENTERED DESCRIPTION

The following page is designed to assist you and your loved one in crafting a simple guide to help others understand how to provide the most effective support. It enables others in the caregiving network, including medical and social supports, to know more about your loved one's needs, history, personality, and what is important to them.

This is called adopting a "person-centered" approach to caregiving. This approach prioritizes acknowledging and respecting the unique characteristics, experiences, and aspirations of each individual, ensuring that care is as fulfilling and effective as possible.



**MY NAME IS:**

What people like and admire about me:

Things that are important to me:

Insert photo

Ways to best support me:

Characteristics of people who support  
me best:

## CARE RECIPIENT INFORMATION

CARE RECIPIENT PERSONAL INFORMATION	
Legal Name (First, Middle, Last)	
Preferred Name or Nickname	
Date of Birth (MM/DD/YYYY)	
Driver's License/State ID #	
Medicaid ID	
Medicare ID	
Military ID	

PERSONAL DOCUMENTS CHECKLIST		
Check that you have these important documents and know their location.		
✓	Item	Location
	Address Books	
	Birth Certificate	
	Driver's License/State ID Card	
	Death Certificate (For Deceased Spouse)	
	Divorce Records	
	Funeral Arrangement Information	
	Immigration Papers	
	Military Records	
	Passport/Travel Documents	
	Pension Documents	
	Social Security Card	

**NOTE: Store critical documents such as birth certificates and social security cards in a secure place, such as a lock box.**

## CAREGIVER CONTACT INFORMATION

Name the people who consistently provide care to the individual. Add additional sheets as needed.

Caregiver Contact Information	
<b>Name</b>	
Relationship	
Phone Number	
Email	
Address	
<b>Name</b>	
Relationship	
Phone Number	
Email	
Address	
<b>Name</b>	
Relationship	
Phone Number	
Email	
Address	
<b>Name</b>	
Relationship	
Phone Number	
Email	
Address	



## OTHER CONTACTS

Use this space to list personal and community support contacts who frequently interact with the individual.

PERSONAL & COMMUNITY SUPPORT CONTACTS	
<b>Transportation</b>	
Name:	Relationship:
Address:	Email:
<b>Meals/Nutrition</b>	
Name:	Relationship:
Address:	Email:
<b>Chores/Home Repairs</b>	
Name:	Relationship:
Address:	Email:
<b>In-Home Support/Respite</b>	
Name:	Relationship:
Address:	Email:
<b>Local Senior Center</b>	
Name:	Relationship:
Address:	Email:
<b>Day Center</b>	
Name:	Relationship:
Address:	Email:
<b>Local Area Agency on Aging</b>	
Name:	Relationship:
Address:	Email:





## OTHER CONTACTS

PERSONAL & COMMUNITY SUPPORT CONTACTS	
<b>Hairdresser/Barber</b>	
Name:	Relationship:
Address:	Email:
<b>Pet Sitter</b>	
Name:	Relationship:
Address:	Email:
<b>Friend</b>	
Name:	Relationship:
Address:	Email:
<b>Friend</b>	
Name:	Relationship:
Address:	Email:
<b>Neighbor</b>	
Name:	Relationship:
Address:	Email:
<b>Other</b>	
Name:	Relationship:
Address:	Email:
<b>Other</b>	
Name:	Relationship:
Address:	Email:
<b>Other</b>	
Name:	Relationship:
Address:	Email:



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**HEALTH**

## MEDICAL PROFILE

Use this page to record information about the individual receiving care that is commonly needed in both emergency and non-emergency scenarios.

BASIC MEDICAL INFORMATION	
Name	
Nickname or Preferred Name	
Address	
Phone Number	
Date of Birth	
Sex	
Gender Identity & Pronouns	
Primary Language	
Secondary Language	
Primary Health Insurance	
ID Number	
Secondary Health Insurance	
ID Number	
Living Will?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Health Care Proxy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Race	
Height	
Weight	
Blood Type	

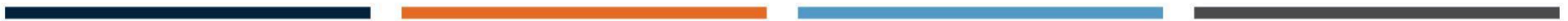
## HEALTH CARE DIRECTORY

Use this page to list the care recipient's insurance and medical record number, medical emergency contacts, and their primary care physician.

Personal Information			
Patient Name (First, Last)	Patient Date of Birth (MM/DD/YYYY)	Patient Medical Record Number (If Applicable)	Patient Insurance Information (Insurance Provider/Policy #)

Emergency Contacts			
Name	Relationship to Patient	Phone Number	Alternate Phone Number

Primary Care Physician				
Name	Office Address	Phone Number	Email	Emergency Instructions



## HEALTH CARE DIRECTORY (SPECIALISTS)

Use this page to list the contact information of the care recipient's medical specialists.

Medical Specialists (e.g., Cardiologist, Neurologist, Psychiatrist)	
<b>Specialty:</b>	
Name:	Phone:
Address:	
Notes:	
<b>Specialty:</b>	
Name:	Phone:
Address:	
Notes:	
<b>Specialty:</b>	
Name:	Phone:
Address:	
Notes:	
<b>Specialty:</b>	
Name:	Phone:
Address:	
Notes:	



HEALTH CARE DIRECTORY (SPECIALISTS)

Medical Specialists (e.g., Cardiologist, Neurologist, Psychiatrist)	
<b>Specialty:</b>	
Name:	Phone:
Address:	
Notes:	
<b>Specialty:</b>	
Name:	Phone:
Address:	
Notes:	
<b>Specialty:</b>	
Name:	Phone:
Address:	
Notes:	
<b>Specialty:</b>	
Name:	Phone:
Address:	
Notes:	



## PREFERRED MEDICAL LOCATIONS

Use this page to record where your loved one would like to go to receive medical care.

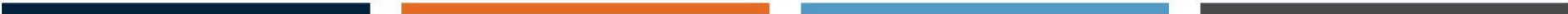
Preferred Medical Locations	
<b>Preferred Hospital:</b>	
Name:	Phone:
Address:	
Notes:	
<b>Preferred Urgent Care Center:</b>	
Name:	Phone:
Address:	
Notes:	
<b>Preferred Pharmacy:</b>	
Name:	Phone:
Address:	
Notes:	
Name:	Phone:
Address:	
Notes:	
Name:	Phone:
Address:	
Notes:	



**MEDICATION LIST**

List all prescriptions, over-the-counter drugs, vitamins, and supplements your loved one uses. Remember to update the list when there is a change.

Rx#	Medicine Name	Dose & Instructions	Treats	Description	Prescriber
000123 (On the bottle)	Generic: amlodipine besylate Brand: NORVASC	123 mg with food in the morning	High blood pressure	White oval tablet	Dr. Habib





MEDICATION LIST

Rx#	Medicine Name	Dose & Instructions	Treats	Description	Prescriber



## MEDICAL HISTORY

Personal Information
Legal Name:
Date of Birth:
Address:
Phone:

### CHECK ALL THAT APPLY:

#### A History Of:

- |   |   |
|---|---|
| <input type="checkbox"/> Alcohol use (# of drinks per week) _____ | <input type="checkbox"/> Heart attack                         |
| <input type="checkbox"/> Autoimmune diseases                      | <input type="checkbox"/> Hepatitis (type) _____               |
| <input type="checkbox"/> Asthma                                   | <input type="checkbox"/> Hernia                               |
| <input type="checkbox"/> Bleeding disorders                       | <input type="checkbox"/> High Blood Pressure (hypertension)   |
| <input type="checkbox"/> Blood clots                              | <input type="checkbox"/> Immuno-compromising condition        |
| <input type="checkbox"/> Bronchitis                               | <input type="checkbox"/> Lupus                                |
| <input type="checkbox"/> Cancer (type) _____                      | <input type="checkbox"/> Mitral valve prolapse (heart murmur) |
| <input type="checkbox"/> Chronic cough                            | <input type="checkbox"/> Osteoporosis or Osteopenia           |
| <input type="checkbox"/> Congestive heart failure                 | <input type="checkbox"/> Rheumatoid arthritis                 |
| <input type="checkbox"/> COPD                                     | <input type="checkbox"/> Seizures                             |
| <input type="checkbox"/> Depression                               | <input type="checkbox"/> Shortness of breath                  |
| <input type="checkbox"/> Diabetes                                 | <input type="checkbox"/> Smoking                              |
| <input type="checkbox"/> Drug Abuse (type) _____                  | <input type="checkbox"/> Stroke                               |
| <input type="checkbox"/> Emphysema                                | <input type="checkbox"/> Thyroid disease                      |
| <input type="checkbox"/> Epilepsy                                 | <input type="checkbox"/> Tuberculosis                         |
| <input type="checkbox"/> Headaches                                | <input type="checkbox"/> Other: _____                         |

### Other

Please check all of the following that you have or use:

- |   |   |                          |
|---|---|--------------------------|
| <input type="checkbox"/> Cane/walker          | <input type="checkbox"/> Hearing aid        | Other:                   |
| <input type="checkbox"/> Communication device | <input type="checkbox"/> Metal implants     | <input type="checkbox"/> |
| <input type="checkbox"/> Contacts             | <input type="checkbox"/> Wheelchair/scooter | <input type="checkbox"/> |
| <input type="checkbox"/> Dental Implants      | <input type="checkbox"/> Oxygen             | <input type="checkbox"/> |
| <input type="checkbox"/> Dentures             | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> |
| <input type="checkbox"/> Glasses              | <input type="checkbox"/> Prosthetics        | <input type="checkbox"/> |





## IMMUNIZATION HISTORY

Utilize this chart to document the immunization history of your loved one. Aim to include as much historical information as possible when completing the chart.

✓	Immunization Name	Date Received	Notes
	COVID-19		
	Tetanus, Diphtheria, Pertussis (Td/Tdap)		
	Influenza		
	Measles, Mumps, Rubella (MMR)		
	Meningococcal (Meningitis)		
	Pneumococcal (Pneumonia)		
	Polio (IPV)		
	Tuberculosis		
	Varicella (Chicken Pox)		
	Zoster (Shingles)		



## EMERGENCY ID CARDS

Complete the cards provided below. After filling them out, cut them out and store them in your wallets for emergency situations.

### Card for the person being cared for:

<p style="text-align: center;"><b>Emergency Medical ID</b></p> <p>Name: _____ DOB: _____</p> <p>Address: _____</p> <p style="text-align: center;"><b>Emergency Contacts:</b></p> <p>Name: _____ Phone: _____</p> <p>Doctor: _____ Phone: _____</p> <p>Hospital: _____ Phone: _____</p>
<p style="text-align: center;"><b>Emergency Medical ID</b></p> <p>Medical Conditions: _____</p> <p>_____</p> <p>_____</p> <p>Allergies: _____</p> <p>_____</p> <p>Medicines: _____</p> <p>_____</p>

**EMERGENCY ID CARDS**

Card for the main caregiver:

<b>IN CASE OF EMERGENCY</b>	
I AM A CAREGIVER	
MY NAME IS:	
<hr/>	
If I'm injured or unavailable, please contact the individuals listed on the back of this card. Ask them to check on the person I am a caregiver for.	
<b>IN CASE OF EMERGENCY</b>	
Name:	Phone:
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

**IMPORTANT:** Do NOT record the name and address of the individual you're caring for to prevent potential risks in case your wallet is stolen. This precaution ensures that their vulnerability isn't exposed to malicious parties. Instead, provide the details of emergency contacts who can be alerted to check on them if necessary.



## HEALTH INFORMATION CHECKLIST

Health Information Checklist			
Check that you have these important documents and know their location.			
✓	Item	Location	Notes
	Medicare Original or Medicare Advantage Documents & Cards		ID Number:
	Medicare Prescription Drug Coverage Documents & Cards		ID Number:
	Medigap Documents & Cards		Company Name: Premium: Payment Schedule:
	Veterans Health System Documents & Cards		ID Number:
	Do Not Resuscitate (DNR) Order		
	Michigan Physician Orders for Scope of Treatment (MI-POST)		
	Living Will		
	Advanced Directives		
	Durable Power of Attorney for Health Care		





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**HOME & FINANCES**

## FINANCIAL CONTACTS

Use this page to record who to contact about your loved one's finances. Attach additional sheets as needed.

Financial Contacts	
<b>BANK</b>	
Name:	Phone:
Address:	Email:
<b>TAX PREPARER</b>	
Name:	Phone:
Address:	Email:
<b>FINANCIAL ADVISOR OR BROKER</b>	
Name:	Phone:
Address:	Email:
<b>FINANCIAL DURABLE POWER OF ATTORNEY OR CONSERVATOR</b>	
Name:	Phone:
Address:	Email:
<b>LAWYER</b>	
Name:	Phone:
Address:	Email:
Name:	Phone:
Address:	Email:
Name:	Phone:
Address:	Email:



## FINANCIAL CONTACTS

Financial Contacts	
Name:	Phone:
Address:	Email:
Name:	Phone:
Address:	Email:
Name:	Phone:
Address:	Email:
Name:	Phone:
Address:	Email:
Name:	Phone:
Address:	Email:
Name:	Phone:
Address:	Email:
Name:	Phone:
Address:	Email:



## FINANCE CHECKLIST

Financial Information & Document Checklist		
Check that you have these important documents and know their location.		
✓	Item	Location
	Bank Records (checking/savings account and routing numbers) - online banking usernames/passwords	
	Debit and Credit Cards	
	Checkbooks	
	Trust Documents	
	Will Documents	
	Agreements & Contracts	
	Federal and State Tax Returns	
	Personal Loan Documents	
	List of Assets and Debts	
	List of Routine Bills	
	Safe Deposit Box (location, box number, keys)	



## ROUTINE BILLS

Document the recurring charges to your loved one's bank account. If needed, attach extra sheets to include all regular subscriptions and billing details.

MORTGAGE/RENT	
Company:	Phone:
Account #:	Website:
How Paid:	Regular Due Date:
Notes:	
ELECTRICITY	
Company:	Phone:
Account #:	Website:
How Paid:	Regular Due Date:
Notes:	
GAS	
Company:	Phone:
Account #:	Website:
How Paid:	Regular Due Date:
Notes:	
WATER/SEWER	
Company:	Phone:
Account #:	Website:
How Paid:	Regular Due Date:
Notes:	



HOMEOWNERS OR RENTER'S INSURANCE	
Company:	Phone:
Account #:	Website:
How Paid:	Regular Due Date:
Notes:	
TRASH	
Company:	Phone:
Account #:	Website:
How Paid:	Regular Due Date:
Notes:	
PHONE	
Company:	Phone:
Account #:	Website:
How Paid:	Regular Due Date:
Notes:	
INTERNET	
Company:	Phone:
Account #:	Website:
How Paid:	Regular Due Date:
Notes:	
CABLE	
Company:	Phone:
Account #:	Website:
How Paid:	Regular Due Date:
Notes:	



## ROUTINE BILLS

Company:	Phone:
Account #:	Website:
How Paid:	Regular Due Date:
Notes:	
Company:	Phone:
Account #:	Website:
How Paid:	Regular Due Date:
Notes:	
Company:	Phone:
Account #:	Website:
How Paid:	Regular Due Date:
Notes:	
Company:	Phone:
Account #:	Website:
How Paid:	Regular Due Date:
Notes:	
Company:	Phone:
Account #:	Website:
How Paid:	Regular Due Date:
Notes:	



## IMPORTANT HOME INFORMATION

### HVAC System

Location of HVAC system:

---

Maintenance schedule (last service date and next scheduled service):

---

Filters (change frequency, filter type, spare location):

---

Emergency shutoff (location and instructions):

---

Thermostat (location and instructions):

---

### Electrical System

Main circuit breaker location:

---

How to reset tripped breaker:

---

Circuit labels (information about what each circuit controls):

---

Emergency shutoff (location and instructions):

---

### Water System

Main water shutoff valve (location):

---

How to turn off water:

---





Other water shutoff valves (location):

---

## **Fire & Carbon Monoxide Safety**

Smoke & carbon monoxide detector locations:

---

Testing schedule (monthly, instructions for testing):

---

Fire extinguishers (location and instructions):

---

Evacuation Plan (brief outline and meeting point):

---

---

---

---

## **Security System**

Type of security system (brand and model):

---

Operation instructions (how to arm, disarm, and change codes):

---

Monitoring contact information:

---

## **Additional Information**

Wi-fi network (network name and password):

---

Key list (who has keys and location of spares):

---





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**TRANSPORTATION**

## TRANSPORTATION CHECKLIST

Transportation Information & Document Checklist			
Check that you have the relevant transportation information on hand, or know where it can be found.			
✓	Item	Notes	Location
	<b>Vehicle</b>	Year: Make: Model: Color: Vehicle Identification Number (VIN):	
	<b>Vehicle #2</b>	Year: Make: Model: Color: Vehicle Identification Number (VIN):	
	<b>Auto Loan Information</b>	Loan Period: Loan Amount: Financier:	
	<b>Vehicle Title(s)</b>		
	<b>Vehicle Registration(s)</b>		
	<b>Vehicle Insurance</b>	Provider/Policy #: Expiration Month(s):	
	<b>Roadside Assistance</b>	Provider/Policy #:	

	<b>Emergency Kit</b>	<input type="checkbox"/> First Aid Kit <input type="checkbox"/> Flashlight <input type="checkbox"/> Blankets <input type="checkbox"/> Salt <input type="checkbox"/> Water <input type="checkbox"/> Spare Tire & Jack <input type="checkbox"/> Jumper Cables/Battery Pack <input type="checkbox"/> List of Emergency Contacts	
	<b>Lifts &amp; Ramps</b>	Installation Date:  Service Recommendations:  Use Instructions:	
	<b>Recreational Vehicle(s)</b>	Description:  Vehicle Identification Number (VIN):  Insurance (Company, Policy #, Renewal Month(s)):	
	<b>Transportation Services</b>	Provider Name:  Cost:  Route Numbers:	



## VEHICLE MAINTENANCE CHECKLIST

Vehicle Maintenance Checklist			
Monitor the condition of your loved one's vehicle, especially if they are still driving or in the process of ceasing to drive, to ensure their safety on the road.			
✓	Item	Notes	Location
	Oil Change	Frequency: Oil Type: Oil Filter:	
	Tire Rotation	Frequency Schedule: Last Rotation Date:	
	Tire Condition	Replacement Schedule: Last Replacement Date:	
	Battery	Last Replacement Date: Expected Lifespan:	
	Brakes	Last Replacement Date: Expected Lifespan:	
	Alignment	Last Alignment Date: Frequency Schedule:	
	Windshield Wipers	Last Changed Date: Replacement Schedule:	
	Other	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

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**ASSESSMENTS**

## Activities of Daily Living (ADL) and Independent Activities of Daily Living Assessment (IADL)

Before embarking on the journey of becoming a primary caregiver, it's essential to understand the specific needs of your loved one. Preserving their autonomy and sense of identity is paramount, not only for their well-being but also for yours. It's vital to recognize that if they're capable of managing certain aspects of their life independently, they should continue to do so. Engaging in an open dialogue with your loved one is the most effective approach to discern their needs. However, when direct communication is not possible or if they're unsure of their needs, unable to express them, or reluctant to discuss them, alternative strategies can help you assess their situation.

**Activities of Daily Living (ADL)** and **Independent Activities of Daily Living (IADL)** are concepts used in healthcare to assess an individual's ability to perform tasks necessary for independent living. ADLs refer to the basic self-care tasks that an individual performs on a daily basis, such as eating, bathing, dressing, and toileting. IADLs are tasks that require a higher level of cognitive and physical ability, such as managing finances, shopping for groceries or clothes, maintaining a residence, managing medications, and meal preparation. Assessing a person's ability to perform ADLs and IADLs helps healthcare professionals, caregivers, and families determine the level of assistance or care an individual requires and aids in planning for that care.

On the following pages, you will find **The Katz Index of Independence in Activities of Daily Living** and **The Lawton Instrumental Activities of Daily Living Scale**. These tools are invaluable in gauging the support your loved one requires. Always consult with healthcare professionals before making significant care decisions.

Reassessing the Activities of Daily Living (ADLs) and Independent Activities of Daily Living (IADLs) of a loved one is an ongoing process. Their needs and abilities can change over time due to aging, illness, or recovery from surgery. It's generally recommended to conduct a reassessment annually. More frequent evaluations may be necessary if there are significant changes in health status, after hospitalization, or if there is a noticeable decline in physical or cognitive abilities.

Regular communication with healthcare professionals can guide the frequency of ADL and IADL assessments. They can offer expert advice based on the specific conditions and needs of your loved one to promote their independence and quality of life.



Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Patient ID # \_\_\_\_\_

### Katz Index of Independence in Activities of Daily Living

Activities Points (1 or 0)	Independence (1 Point)	Dependence (0 Points)
	<b>NO</b> supervision, direction or personal assistance.	<b>WITH</b> supervision, direction, personal assistance or total care.
<b>BATHING</b> Points: _____	<b>(1 POINT)</b> Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	<b>(0 POINTS)</b> Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
<b>DRESSING</b> Points: _____	<b>(1 POINT)</b> Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	<b>(0 POINTS)</b> Needs help with dressing self or needs to be completely dressed.
<b>TOILETING</b> Points: _____	<b>(1 POINT)</b> Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	<b>(0 POINTS)</b> Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
<b>TRANSFERRING</b> Points: _____	<b>(1 POINT)</b> Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	<b>(0 POINTS)</b> Needs help in moving from bed to chair or requires a complete transfer.
<b>CONTINENCE</b> Points: _____	<b>(1 POINT)</b> Exercises complete self control over urination and defecation.	<b>(0 POINTS)</b> Is partially or totally incontinent of bowel or bladder
<b>FEEDING</b> Points: _____	<b>(1 POINT)</b> Gets food from plate into mouth without help. Preparation of food may be done by another person.	<b>(0 POINTS)</b> Needs partial or total help with feeding or requires parenteral feeding.
<b>TOTAL POINTS:</b> _____ <b>SCORING:</b> 6 = High ( <i>patient independent</i> ) 0 = Low ( <i>patient very dependent</i> )		

Source:

try this: Best Practices in Nursing Care to Older Adults, The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, [www.hartfordign.org](http://www.hartfordign.org).

## Katz Index of Independence in Activities of Daily Living (ADL)

By: Meredith Wallace, PhD, APRN, BC, Fairfield University School of Nursing, and Mary Shelkey, PhD, ARNP, Virginia Mason Medical Center

**WHY:** Normal aging changes and health problems frequently show themselves as declines in the functional status of older adults. Decline may place the older adult on a spiral of iatrogenesis leading to further health problems. One of the best ways to evaluate the health status of older adults is through functional assessment which provides objective data that may indicate future decline or improvement in health status, allowing the nurse to intervene appropriately.

**BEST TOOL:** The Katz Index of Independence in Activities of Daily Living, commonly referred to as the Katz ADL, is the most appropriate instrument to assess functional status as a measurement of the client's ability to perform activities of daily living independently. Clinicians typically use the tool to detect problems in performing activities of daily living and to plan care accordingly. The Index ranks adequacy of performance in the six functions of *bathing, dressing, toileting, transferring, continence, and feeding*. Clients are scored yes/no for independence in each of the six functions. A score of 6 indicates full function, 4 indicates moderate impairment, and 2 or less indicates severe functional impairment.

**TARGET POPULATION:** The instrument is most effectively used among older adults in a variety of care settings, when baseline measurements, taken when the client is well, are compared to periodic or subsequent measures.

**VALIDITY AND RELIABILITY:** In the thirty-five years since the instrument has been developed, it has been modified and simplified and different approaches to scoring have been used. However, it has consistently demonstrated its utility in evaluating functional status in the elderly population. Although no formal reliability and validity reports could be found in the literature, the tool is used extensively as a flag signaling functional capabilities of older adults in clinical and home environments.

**STRENGTHS AND LIMITATIONS:** The Katz ADL Index assesses basic activities of daily living. It does not assess more advanced activities of daily living. Katz developed another scale for instrumental activities of daily living such as heavy housework, shopping, managing finances and telephoning. Although the Katz ADL Index is sensitive to changes in declining health status, it is limited in its ability to measure small increments of change seen in the rehabilitation of older adults. A full comprehensive geriatric assessment should follow when appropriate. The Katz ADL Index is very useful in creating a common language about patient function for all practitioners involved in overall care planning and discharge planning.

### MORE ON THE TOPIC:

Best practice information on care of older adults: [www.ConsultGeriRN.org](http://www.ConsultGeriRN.org).

Graf, C. (2006). Functional decline in hospitalized older adults. *AJN*, 106(1), 58-67.

Katz, S., Down, T.D., Cash, H.R., & Grotz, R.C. (1970) Progress in the development of the index of ADL. *The Gerontologist*, 10(1), 20-30.

Katz, S. (1983). Assessing self-maintenance: Activities of daily living, mobility and instrumental activities of daily living. *JAGS*, 31(12), 721-726.

Kreševic, D.M., & Mezey, M. (2003). Assessment of function. In M. Mezey, T. Fulmer, I. Abraham (Eds.), D. Zwicker (Managing Ed.), *Geriatric nursing protocols for best practice* (2nd ed., pp 31-46). NY: Springer Publishing Co., Inc.

Mick, D.J., & Ackerman, M.H. (2004, Sept). Critical care nursing for older adults: Pathophysiological and functional considerations. *Nursing Clinics of North America*, 39(3), 473-93.

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Patient ID #** \_\_\_\_\_

**LAWTON - BRODY  
INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE (I.A.D.L.)**

**Scoring:** For each category, circle the item description that most closely resembles the client's highest functional level (either 0 or 1).

<b>A. Ability to Use Telephone</b>		<b>E. Laundry</b>	
1. Operates telephone on own initiative-looks up and dials numbers, etc.	1	1. Does personal laundry completely	1
2. Dials a few well-known numbers	1	2. Launders small items-rinses stockings, etc.	1
3. Answers telephone but does not dial	1	3. All laundry must be done by others	0
4. Does not use telephone at all	0		
<b>B. Shopping</b>		<b>F. Mode of Transportation</b>	
1. Takes care of all shopping needs independently	1	1. Travels independently on public transportation or drives own car	1
2. Shops independently for small purchases	0	2. Arranges own travel via taxi, but does not otherwise use public transportation	1
3. Needs to be accompanied on any shopping trip	0	3. Travels on public transportation when accompanied by another	1
4. Completely unable to shop	0	4. Travel limited to taxi or automobile with assistance of another	0
		5. Does not travel at all	0
<b>C. Food Preparation</b>		<b>G. Responsibility for Own Medications</b>	
1. Plans, prepares and serves adequate meals independently	1	1. Is responsible for taking medication in correct dosages at correct time	1
2. Prepares adequate meals if supplied with ingredients	0	2. Takes responsibility if medication is prepared in advance in separate dosage	0
3. Heats, serves and prepares meals, or prepares meals, or prepares meals but does not maintain adequate diet	0	3. Is not capable of dispensing own medication	0
4. Needs to have meals prepared and served	0		
<b>D. Housekeeping</b>		<b>H. Ability to Handle Finances</b>	
1. Maintains house alone or with occasional assistance (e.g. "heavy work domestic help")	1	1. Manages financial matters independently (budgets, writes checks, pays rent, bills, goes to bank), collects and keeps track of income	1
2. Performs light daily tasks such as dish washing, bed making	1	2. Manages day-to-day purchases, but needs help with banking, major purchases, etc.	1
3. Performs light daily tasks but cannot maintain acceptable level of cleanliness	1	3. Incapable of handling money	0
4. Needs help with all home maintenance tasks	1		
5. Does not participate in any housekeeping tasks	0		
<b>Score</b>		<b>Score</b>	

**Total score** \_\_\_\_\_

A summary score ranges from 0 (low function, dependent) to 8 (high function, independent) for women and 0 through 5 for men to avoid potential gender bias.



# try this: **Best Practices in Nursing Care to Older Adults**

from **The Hartford Institute for Geriatric Nursing**  
New York University, College of Nursing

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New York University College of Nursing

## The Lawton Instrumental Activities of Daily Living (IADL) Scale

By: *Carla Graf, MS, APRN, BC, University of California, San Francisco*

**WHY:** The assessment of functional status is critical when caring for older adults. Normal aging changes, acute illness, worsening chronic illness, and hospitalization can contribute to a decline in the ability to perform tasks necessary to live independently in the community. The information from a functional assessment can provide objective data to assist with targeting individualized rehabilitation needs or to plan for specific in-home services such as meal preparation, nursing care, home-maker services, personal care, or continuous supervision. A functional assessment can also assist the clinician to focus on the person's baseline capabilities, facilitating early recognition of changes that may signify a need either for additional resources or for a medical work-up (Gallo, 2006).

**BEST TOOL:** The Lawton Instrumental Activities of Daily Living Scale (IADL) is an appropriate instrument to assess independent living skills (Lawton & Brody, 1969). These skills are considered more complex than the basic activities of daily living as measured by the Katz Index of ADLs (See *Try this:* Katz Index of ADLs). The instrument is most useful for identifying how a person is functioning at the present time, and to identify improvement or deterioration over time. There are eight domains of function measured with the Lawton IADL scale. Women are scored on all 8 areas of function; historically, for men, the areas of food preparation, housekeeping, laundering are excluded. Clients are scored according to their highest level of functioning in that category. A summary score ranges from 0 (low function, dependent) to 8 (high function, independent) for women, and 0 through 5 for men.

**TARGET POPULATION:** This instrument is intended to be used among older adults, and can be used in community or hospital settings. The instrument is not useful for institutionalized older adults. It can be used as a baseline assessment tool and to compare baseline function to periodic assessments.

**VALIDITY AND RELIABILITY:** Few studies have been performed to test the Lawton IADL scale psychometric properties. The Lawton IADL Scale was originally tested concurrently with the Physical Self-Maintenance Scale (PSMS). Reliability was established with twelve subjects interviewed by one interviewer with the second rater present but not participating in the interview process. Inter-rater reliability was established at .85. The validity of the Lawton IADL was tested by determining the correlation of the Lawton IADL with four scales that measured domains of functional status, the Physical Classification (6-point rating of physical health), Mental Status Questionnaire (10-point test of orientation and memory), Behavior and Adjustment rating scales (4-6-point measure of intellectual, person, behavioral and social adjustment), and the PSMS (6-item ADLs). A total of 180 research subjects participated in the study, however, few received all five evaluations. All correlations were significant at the .01 or .05 level. To avoid potential gender bias at the time the instrument was developed, specific items were omitted for men. This assessment instrument is widely used both in research and in clinical practice.

**STRENGTHS AND LIMITATIONS:** The Lawton IADL is an easy to administer assessment instrument that provides self-reported information about functional skills necessary to live in the community. Administration time is 10-15 minutes. Specific deficits identified can assist nurses and other disciplines in planning for safe discharge. Limitations of the instrument can include the self-report or surrogate report method of administration rather than a demonstration of the functional task. This may lead either to over-estimation or under-estimation of ability. In addition, the instrument may not be sensitive to small, incremental changes in function.

**FOLLOW-UP:** The identification of new disabilities in these functional domains warrants intervention and further assessment to prevent ongoing decline and to promote safe living conditions for older adults. If using the Lawton IADL tool with an acute hospitalization, nurses should communicate any deficits to the physicians and social workers/case managers for appropriate discharge planning.

### MORE ON THE TOPIC:

Best practice information on care of older adults: [www.ConsultGerIRN.org](http://www.ConsultGerIRN.org).

Gallo, J.J., & Paveza, G.J. (2006). Activities of daily living and instrumental activities of daily living assessment. In J.J. Gallo, H.R. Bogner, T. Fulmer, & G.J. Paveza (Eds.), *Handbook of Geriatric Assessment* (4<sup>th</sup> ed., pp. 193-240). MA: Jones and Bartlett Publishers.

Graf, C. (2006). Functional decline in hospitalized older adults. *AJN*, 106(1), 58-67.

Lawton, M.P., & Brody, E.M. (1969). Assessment of older people: Self-maintaining and instrumental activities of daily living. *The Gerontologist*, 9(3), 179-186.

Pearson, V. (2000). Assessment of function. In R. Kane, & R. Kane (Eds.), *Assessing Older Persons. Measures, Meaning and Practical Applications* (pp. 17-48). New York: Oxford University Press.

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## HOME SAFETY ASSESSMENT

To age in place safely, it might be necessary to modify the living environment to prevent injuries. Some adjustments, such as changing cabinet hardware or securing rugs, can be accomplished quickly with minimal expertise. However, more extensive structural changes may be required to maintain accessibility depending on the needs of your loved one. In limited situations financial support for home modifications may be available.

**For more information on local support services, contact The Senior Alliance at 734-722-2830.**

Before initiating modifications, assess the current home environment to determine necessary changes and identify those that can be managed independently. The following sections provide a general overview of home safety recommendations. Keep in mind that different homes and personal circumstances may require tailored adaptations.

General Items				
Item	Yes	No	N/A	Notes
Smoke detectors installed on every floor and near bedrooms.				
Carbon monoxide detectors installed on each floor and near bedrooms.				
Smoke and carbon monoxide detectors tested and functional.				
At least one fire extinguisher in the home (note the location and expiration date).				
List of emergency contacts posted in an accessible location.				
Fire escape plan posted in an accessible location.				
All cabinet hardware is easy to open (pulls are generally easier than knobs).				

Lighting				
Item	Yes	No	N/A	Notes
Entrances and exits are well lit (motion detection preferred).				
Hallways and stairs are well lit with switches at both ends.				
Switches are push activated for accessibility.				
Night lights installed in hallways, bathrooms, and bedrooms.				



Floors and Walkways				
Item	Yes	No	N/A	Notes
Rugs and carpets are securely fastened or removed if they pose a tripping hazard.				
Hallways and walkways are free of clutter.				
Electrical cords are secured away from walkways.				

Stairs and Steps				
Item	Yes	No	N/A	Notes
Handrails are secure and present on both sides of the stairways.				
Steps are clearly visible, possibly enhanced with contrasting tape.				
Non-slip surfaces or treads are present on steps.				

Bedrooms				
Item	Yes	No	N/A	Notes
Bed height suitable for safe transfers in and out of bed.				
Phone accessible from the bed for emergencies.				
Clear pathway from bed to bathroom.				



Bathrooms				
Item	Yes	No	N/A	Notes
Grab bars installed in the shower, tub, and near the toilet.				
Non-slip mats placed in the tub and shower area.				
Toilet height is appropriate, with raised seat if necessary.				
Shower is accessible, with walk-in features, bath bench, or shower seat if needed.				
Bathroom vanity is at a suitable height, with an accessible opening for a wheelchair if required.				

Kitchen				
Item	Yes	No	N/A	Notes
Frequently used items stored at an easily reachable height.				
Appliance knobs are easy to use and clearly marked.				
Automatic shut-off features on appliances are functional if available.				
Flammable items are kept away from the stove and oven.				



## SELF-CARE ASSESSMENT

Each question can be answered on a scale of 1 to 5:

- 1: Never or almost never
- 2: Rarely
- 3: Sometimes
- 4: Often
- 5: Always or almost always

Physical Health	Score
I follow my doctor's recommendations on engaging in physical exercise.	
I get regular medical and dental care each year.	
I address and follow-up with health concerns.	
I eat a nutritionally balanced diet.	
I get an adequate amount of sleep each night.	
I feel rested after sleeping and have good energy throughout the day.	
Mental and Emotional Health	Score
I manage stress effectively.	
I have someone available to talk to about my feelings.	
I engage in enjoyable activities or hobbies each day.	
I say "no" to extra responsibilities if I can't handle them well.	
I maintain a positive mood and outlook.	
I notice and change negative self-talk.	
I allow myself to express my emotions.	
Spiritual and Religious Health	Score
I engage in spiritual or meditative practices	
I spend time outdoors each day (weather permitting).	
I use spirituality or religion as a coping strategy.	
I feel connected to a larger purpose or community.	

## SCORING

Add up the scores from each section. Each question's maximum score is 5, making the total maximum scores for each section as follows:

- Physical Health: 30 points (6 questions x 5 points each)
- Mental and Emotional Health: 35 points (7 questions x 5 points each)
- Spiritual and Religious Health: 20 points (4 questions x 5 points each)

**The overall maximum score is 85 points.**

**MY SCORE:** \_\_\_\_\_

Interpretive Guidelines:

- **68 - 85: Excellent self-care.** You are doing a great job managing your well-being in all aspects. Keep up the good work and continue your practices.
- **51 - 67: Good self-care.** You're taking care of yourself well, but there might be some areas that could benefit from more attention. Explore ways to enhance these aspects of your self-care routine.
- **34 - 50: Moderate self-care.** You're doing okay, but there's room for improvement. Identifying and focusing on areas that need more attention can help you feel even better.
- **17 - 33: Needs improvement.** Some aspects of your self-care routine could benefit from changes and additional support. Consider seeking advice on how to strengthen these areas.
- **0 - 16: Needs attention.** It's important to seek guidance and possibly professional support to enhance your self-care practices. You deserve to feel better, and help is available.

This self-care assessment is designed to help you reflect on key aspects of your well-being, though it is not exhaustive. True self-care isn't just a checklist item to be marked off occasionally; it should be integrated into your everyday life as a continuous practice.

**IMPORTANT: If you are experiencing thoughts of harming yourself or others, it is crucial to seek help immediately. In such situations, call the Suicide and Crisis Lifeline at 988, or emergency services at 911 immediately.**

The Senior  
**Alliance**  
**Caregiver Binder**



**PLANNING**

DATE :

(S) (M) (T) (W) (T) (F) (S)

MOOD :



TIME	SCHEDULE
6:00 AM	
7:00 AM	
8:00 AM	
9:00 AM	
10:00 AM	
11:00 AM	
12:00 PM	
1:00 PM	
2:00 PM	
3:00 PM	
4:00 PM	
5:00 PM	
6:00 PM	
7:00 PM	
8:00 PM	
9:00 PM	
10:00 PM	
11:00 PM	
12:00 AM	
1:00 AM	
2:00 AM	
3:00 AM	
4:00 AM	
5:00 AM	
6:00 AM	

TO DO LIST

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

URGENT!

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

NOTES

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

TOMORROW

\_\_\_\_\_  
 \_\_\_\_\_

# The Senior Alliance WEEKLY PLANNER

## Weekly priorities

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## Notes

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

## Checklist

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## Appointment

## Reminder

# The Senior Alliance MONTHLY PLANNER

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MON	TUE	WED	THU	FRI	SAT	SUN

## TO DO

<input type="checkbox"/>	-----
<input type="checkbox"/>	-----
<input type="checkbox"/>	-----
<input type="checkbox"/>	-----
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<input type="checkbox"/>	-----
<input type="checkbox"/>	-----
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## GOALS

<input type="checkbox"/>	-----
<input type="checkbox"/>	-----
<input type="checkbox"/>	-----
<input type="checkbox"/>	-----

## NOTES

The Senior  
**Alliance**  
**Caregiver Binder**



**OTHER**

## IMMIGRATION CHECKLIST

Immigration Document Checklist			
If your loved one is in the process of immigrating or has recently done so, help them keep track of their important documents from the list of common forms below.			
✓	Item	Notes	Location
	Form N-550, Certificate of Naturalization		
	Form N-570, Certificate of Naturalization		
	Form N-560, Certificate of Citizenship		
	Form N-561, Certificate of Citizenship		
	Form I-551, Permanent Resident Card (Green Card)		
	Temporary I-551, Machine Readable Immigrant Visa (MRIV)		
	Temporary I-551, Permanent Resident Stamp		
	Form I-327, Permit to Re-Enter		
	Form I-571, Refugee Travel Document		
	Form I-766, Employment Authorization Document Card		
	Form I-94, Arrival/Departure Record		
	Unexpired Foreign Passport		
	Form I-797, Notice of Action		
	Form DS-2019, Certificate of Eligibility for Exchange Visitor Status		
	Form I-220A, Order of Release on Recognizance		



	Form I-220B, Order of Supervision		
	Form I-20, Certificate of Eligibility for Nonimmigrant Student Status – For Academic and Language Students OR Form I-20, Certificate of Eligibility for Nonimmigrant Student Status – For Vocational Students		
	Form I-862, Notice to Appear		
	Form I-385, Alien Booking Record		
	Other Documents		



## PUBLIC BENEFITS CHECKLIST

Public Benefits Checklist			
Mark if the person being cared for receives any of the following public benefits.			
✓	Item	Yes	No
	Supplemental Nutrition Assistance Program (SNAP)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Senior Farmers Market Nutrition Program	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Supplemental Security Income (SSI)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Property Tax Assistance	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Medicare Part D Assistance	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Medicare Parts A, B, and D Premium Support	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Medicaid	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Transportation Assistance	<input type="checkbox"/> YES	<input type="checkbox"/> NO



