WrenSong
FAMILY CARE DECISIONS. GUIDED BY TRUST.

WrenSong Assisted Living Care Planner

A private, fillable organizer for assisted living and memory care preparation.

FILL IT OUT LOCALLY. SAVE IT LOCALLY. SHARE IT ONLY WHEN YOU CHOOSE.

This file has no submit button and no connection for returning completed information to WrenSong.

PREPARED BY

PACKET STARTED

RESIDENT NAME (OPTIONAL - STORED ONLY IN THIS FILE)

TARGET MOVE-IN DATE

IMPORTANT

This organizer is not medical or legal advice and does not replace any form required by a selected facility.

How to use this private packet

A calm, guided way to gather information without placing completed answers in WrenSong storage.

PRIVACY DESIGN

WrenSong may track that you marked an item complete on the website. WrenSong does not receive, read, upload, or store anything entered into this downloaded PDF.

1. **Download first**
   Save this packet to a private folder on your computer before entering information.

2. **Move through the tabs**
   Use the tabs at the top or the PDF bookmark panel to jump between sections.

3. **Complete only what helps**
   Requirements vary. Confirm the facility's exact forms, signatures and timeframes.

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   Print or send only the pages requested. Completed information may be highly sensitive.

PROTECT YOUR COPY

HELPFUL SAFEGUARDS

- [ ] Use a password-protected device
- [ ] Avoid unencrypted email
- [ ] Delete outdated copies
- [ ] Store in a private folder
- [ ] Share only requested pages
- [ ] Keep a backup you control

NO RETURN PATH

This PDF contains no Upload, Submit, Email to WrenSong, or Send to Facility action. A family may separately choose how and when to share its own copy.

Packet contents

Select any form below. The same destinations appear in the tabs and bookmark panel.

Resident and Move-In Snapshot

A single place for basic planning details. Everything entered here remains inside your saved copy.

USE WITH CARE

This page may identify the resident. Keep the completed file private and share only when necessary.

RESIDENT INFORMATION

FULL LEGAL NAME

PREFERRED NAME

DATE OF BIRTH

PHONE

PRIMARY LANGUAGE

CURRENT ADDRESS

MOVE-IN PLAN

SELECTED FACILITY

TARGET MOVE-IN DATE

FACILITY CONTACT

PHONE

CARE SETTING BEING CONSIDERED

- ☐ Standard assisted living
- ☐ Memory care
- ☐ Not yet decided

FAMILY COORDINATOR

NAME

RELATIONSHIP

PHONE

EMAIL

☐ **I reviewed this page and saved this packet on my own device.**

Emergency Contacts

List the people a community should contact and the order in which they should be reached.

PRIMARY CONTACT

NAME

RELATIONSHIP

MOBILE PHONE

ALTERNATE PHONE

EMAIL

ADDRESS

PREFERRED CONTACT METHOD

ROLES

- [ ] Emergency contact
- [ ] Healthcare agent
- [ ] Financial contact
- [ ] Billing contact

BACKUP CONTACT

NAME

RELATIONSHIP

MOBILE PHONE

ALTERNATE PHONE

EMAIL

ROLES

- [ ] Emergency contact
- [ ] Healthcare agent
- [ ] Financial contact
- [ ] Billing contact

CONTACT NOTES

BEST ORDER, AVAILABILITY, LANGUAGE OR OTHER INSTRUCTIONS

- [ ] **I reviewed this page and saved this packet on my own device.**

Insurance and Benefits Organizer

Record active health and prescription coverage. Policy numbers and identifiers remain in this local file.

SENSITIVE IDENTIFIERS

Insurance member numbers, Medicare or Medicaid identifiers, and card images can identify the resident. Store this completed file securely.

PRIMARY HEALTH COVERAGE

CARRIER / PLAN

PLAN TYPE

MEMBER ID

GROUP NUMBER

EFFECTIVE DATE

CUSTOMER SERVICE PHONE

CLAIMS / PORTAL

GOVERNMENT COVERAGE

COVERAGE HELD

- [ ] Medicare Part A
- [ ] Medicare Part B
- [ ] Medicare Advantage
- [ ] Medicaid / ALTCS
- [ ] TRICARE / VA
- [ ] None

PROGRAM / PLAN

IDENTIFIER

CARD AND DOCUMENT CHECK

COPIES AVAILABLE

- [ ] Front of current card
- [ ] Back of current card
- [ ] Benefit summary
- [ ] Recent eligibility notice

- [ ] **I reviewed this page and saved this packet on my own device.**

Insurance and Benefits Organizer

Add prescription and long-term care coverage, then note open questions.

PRESCRIPTION COVERAGE

PLAN / PBM

MEMBER ID

BIN

PCN

GROUP

CUSTOMER SERVICE PHONE

PREFERRED PHARMACY NETWORK

LONG-TERM CARE INSURANCE

CARRIER

POLICY NUMBER

CLAIMS PHONE

CLAIM NUMBER

ELIMINATION PERIOD

CLAIM STATUS

- [ ] Not reviewed
- [ ] Eligibility confirmed
- [ ] Claim started
- [ ] Benefits active

OTHER BENEFITS

PROGRAM / SOURCE

CONTACT

QUESTIONS, RENEWAL DATES, EXCLUSIONS OR FOLLOW-UP

- [ ] **I reviewed this page and saved this packet on my own device.**

Physician Document Request

Cover information for a physician, practice, or medical-records request. Confirm the facility's final requirements.

REQUEST INFORMATION

DATE OF REQUEST

REQUESTED COMPLETION DATE

PAGES ATTACHED

PRIORITY

☐ Routine ☐ Urgent

RESIDENT INFORMATION

FULL LEGAL NAME

PREFERRED NAME

DATE OF BIRTH

PHONE

PATIENT / RECORD NUMBER

ADDRESS

PLANNED FACILITY

PLANNED ADMISSION DATE

SENDING PARTY

FAMILY CONTACT

RELATIONSHIP

PHONE

EMAIL

PHYSICIAN OR PRACTICE

PHYSICIAN

PRACTICE

DEPARTMENT

PHONE

FAX

RECORDS CONTACT / PORTAL

☐ **I reviewed this page and saved this packet on my own device.**

Physician Document Request

Check only the documents that are useful or required.

DOCUMENTS REQUESTED

- [ ] Physician assessment
- [ ] Current medication list
- [ ] Allergy information
- [ ] Immunization record
- [ ] Hospital discharge summary
- [ ] Laboratory results
- [ ] Behavioral health records
- [ ] Dietary orders
- [ ] Durable medical equipment orders
- [ ] Medical history and diagnoses
- [ ] Signed medication orders
- [ ] Recent physical examination
- [ ] TB screening / chest X-ray
- [ ] Rehabilitation discharge summary
- [ ] Cognitive evaluation
- [ ] Mobility / transfer assessment
- [ ] Therapy records
- [ ] Other document

OTHER DOCUMENT OR SPECIAL INSTRUCTIONS

FACILITY FORM INFORMATION

REQUIREMENTS

- [ ] Facility-specific form attached
- [ ] Form must be signed
- [ ] Form must be completed
- [ ] Form must be dated

MAXIMUM AGE OF ASSESSMENT

WHO MUST COMPLETE THE FORM

ADDITIONAL FACILITY INSTRUCTIONS

- [ ] **I reviewed this page and saved this packet on my own device.**

Physician Document Request

Use this page to specify delivery and track follow-up.

DELIVERY INSTRUCTIONS

RETURN METHOD

- [ ] Return to family
- [ ] Send directly to facility
- [ ] Fax
- [ ] Secure email
- [ ] Facility portal
- [ ] Mail

RETURN ADDRESS, FAX, SECURE EMAIL OR PORTAL INSTRUCTIONS

AUTHORIZATION

AUTHORIZATION STATUS

- [ ] Release authorization attached
- [ ] Authorization already on file
- [ ] Signature required
- [ ] No authorization requested

SIGNATURE (IF APPROPRIATE)

DATE

TRACKING

REQUEST SENT

DELIVERY METHOD

FOLLOW-UP DATE

RECEIPT CONFIRMED

DOCUMENTS RECEIVED

MISSING ITEMS

TRACKING NOTES

- [ ] **I reviewed this page and saved this packet on my own device.**

Current Medication List

Include prescription medicines, over-the-counter products, vitamins, supplements and as-needed medicines.

VERIFY BEFORE MOVE-IN

Medication lists change. Ask the selected facility what must be physician-signed and how recent the list must be.

RESIDENT AND REVIEW

RESIDENT NAME

LIST REVIEWED ON

REVIEWED WITH

PREFERRED PHARMACY

MEDICATIONS 1-4

1. MEDICATION AND STRENGTH

DOSE / ROUTE

SCHEDULE / REASON

PRESCRIBER

2. MEDICATION AND STRENGTH

DOSE / ROUTE

SCHEDULE / REASON

PRESCRIBER

3. MEDICATION AND STRENGTH

DOSE / ROUTE

SCHEDULE / REASON

PRESCRIBER

4. MEDICATION AND STRENGTH

DOSE / ROUTE

SCHEDULE / REASON

PRESCRIBER

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Current Medication List

Continue the medication list and record allergies or important handling notes.

MEDICATIONS 5-8

5. MEDICATION AND STRENGTH

DOSE / ROUTE

SCHEDULE / REASON

PRESCRIBER

6. MEDICATION AND STRENGTH

DOSE / ROUTE

SCHEDULE / REASON

PRESCRIBER

7. MEDICATION AND STRENGTH

DOSE / ROUTE

SCHEDULE / REASON

PRESCRIBER

8. MEDICATION AND STRENGTH

DOSE / ROUTE

SCHEDULE / REASON

PRESCRIBER

SAFETY AND ADMINISTRATION

MEDICATION ALLERGIES AND REACTIONS

AS-NEEDED INSTRUCTIONS, SWALLOWING NEEDS, STORAGE OR OTHER NOTES

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Pharmacy Information

Record the current pharmacy and any pharmacy the selected facility requires or prefers.

CURRENT PHARMACY

PHARMACY NAME

PHONE

ADDRESS

FAX

CONTACT / PHARMACIST

HOURS

DELIVERY AVAILABLE

FACILITY-PREFERRED PHARMACY

PHARMACY NAME

PHONE

ADDRESS

FAX

TRANSFER STATUS

- [ ] Not discussed
- [ ] Transfer required
- [ ] Transfer requested
- [ ] Transfer complete

COVERAGE AND DELIVERY

PRESCRIPTION PLAN / PBM

MEMBER ID

DELIVERY SCHEDULE

COPAY / BILLING CONTACT

PACKAGING, REFILL, CONTROLLED-MEDICATION OR OTHER INSTRUCTIONS

- [ ] **I reviewed this page and saved this packet on my own device.**

Healthcare Provider Contacts

Keep physicians, specialists, hospitals and medical-records contacts together.

RESIDENT AND WORKBOOK

RESIDENT NAME

DATE OF BIRTH

SELECTED FACILITY

PLANNED MOVE-IN

PREPARED BY

LAST UPDATED

PRIMARY CARE PROVIDER

PROVIDER NAME

PRACTICE

SPECIALTY

PHONE

FAX

DATE LAST SEEN

ADDRESS

RECORDS CONTACT / PORTAL

NEXT APPOINTMENT

INSURANCE OVERVIEW

PRIMARY CARRIER

MEMBER / POLICY NUMBER

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Healthcare Provider Contacts

Specialists and the reasons they are involved in care.

SPECIALIST 1

PROVIDER | SPECIALTY | PRACTICE

PHONE | FAX | DATE LAST SEEN

REASON FOR CARE | NEXT APPOINTMENT

SPECIALIST 2

PROVIDER | SPECIALTY | PRACTICE

PHONE | FAX | DATE LAST SEEN

REASON FOR CARE | NEXT APPOINTMENT

SPECIALIST 3

PROVIDER | SPECIALTY | PRACTICE

PHONE | FAX | DATE LAST SEEN

REASON FOR CARE | NEXT APPOINTMENT

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Healthcare Provider Contacts

Other professionals and services involved in the resident's care.

PROVIDER OR SERVICE 1

NAME | ORGANIZATION | SERVICE

PHONE | FAX | PRIMARY CONTACT

ADDRESS / NOTES

PROVIDER OR SERVICE 2

NAME | ORGANIZATION | SERVICE

PHONE | FAX | PRIMARY CONTACT

ADDRESS / NOTES

PROVIDER OR SERVICE 3

NAME | ORGANIZATION | SERVICE

PHONE | FAX | PRIMARY CONTACT

ADDRESS / NOTES

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Healthcare Provider Contacts

Hospital preferences and medical-records coordination.

HOSPITAL AND URGENT CARE PREFERENCES

PREFERRED HOSPITAL

ALTERNATE HOSPITAL

PREFERRED URGENT CARE

EMERGENCY DEPARTMENT COMMONLY USED

MOST RECENT HOSPITAL STAY

MOST RECENT REHABILITATION STAY

RECORDS COORDINATION

WHERE ARE THE MOST COMPLETE MEDICAL RECORDS HELD?

RECORDS CONTACT

RELEASE COMPLETED?

RECORDS REQUESTED

RECORDS RECEIVED

FOLLOW-UP NEEDED

RECORDS NOTES

☐ **I reviewed this page and saved this packet on my own device.**

Advance Directive Locator

Use this page to locate and review an existing document. It is not an advance directive and does not create legal authority.

DOCUMENT LOCATOR ONLY

Do not use this organizer as a substitute for a state-specific legal form or advice from a qualified professional.

DOCUMENT STATUS

- ☐ Exists
- ☐ Needs review
- ☐ Not applicable
- ☐ Not located
- ☐ Needs replacement
- ☐ Unsure

DOCUMENT TITLE / TYPE

DATE SIGNED

STATE SIGNED IN

ATTORNEY / PREPARER

WHERE IT IS KEPT

ORIGINAL LOCATION

DIGITAL COPY LOCATION

COPIES HELD BY

- ☐ Resident
- ☐ Primary physician
- ☐ Facility
- ☐ Healthcare agent
- ☐ Hospital
- ☐ Other family

REVIEW

HEALTHCARE AGENT NAME

PHONE

FACILITY REVIEWED

REVIEW DATE

NEXT REVIEW

QUESTIONS OR ACTIONS - DO NOT SUMMARIZE PRIVATE CARE WISHES UNLESS NEEDED

☐ **I reviewed this page and saved this packet on my own device.**

Healthcare Power of Attorney Locator

Track an existing healthcare power of attorney and the people named in it. This page does not appoint an agent.

DOCUMENT LOCATOR ONLY

Authority, activation standards and terminology vary by state and document. Rely on the signed instrument and qualified advice.

DOCUMENT STATUS

- [ ] Exists
- [ ] Not located
- [ ] Needs review
- [ ] Needs replacement
- [ ] Not applicable
- [ ] Unsure

DOCUMENT TITLE

DATE SIGNED

STATE SIGNED IN

ORIGINAL LOCATION

PEOPLE NAMED IN THE DOCUMENT

PRIMARY AGENT

RELATIONSHIP

PHONE

EMAIL

SUCCESSOR AGENT

PHONE

PRACTICAL REVIEW

COPIES HELD BY

- [ ] Primary agent
- [ ] Successor agent
- [ ] Physician
- [ ] Hospital
- [ ] Facility
- [ ] Other

ACTIVATION, REVIEW OR FACILITY QUESTIONS

- [ ] **I reviewed this page and saved this packet on my own device.**

Financial Power of Attorney Locator

Track an existing financial power of attorney. This page does not grant authority or replace the signed document.

DOCUMENT LOCATOR ONLY

Do not list passwords, PINs or online-banking credentials anywhere in this packet.

DOCUMENT STATUS

- [ ] Exists
- [ ] Not located
- [ ] Needs review
- [ ] Needs replacement
- [ ] Not applicable
- [ ] Unsure

DOCUMENT TITLE

DATE SIGNED

STATE SIGNED IN

ORIGINAL LOCATION

PEOPLE NAMED IN THE DOCUMENT

PRIMARY AGENT

RELATIONSHIP

PHONE

EMAIL

SUCCESSOR AGENT

PHONE

ADMISSION COORDINATION

BILLING CONTACT

PHONE

FACILITY STATUS

- [ ] Copy requested
- [ ] Copy available
- [ ] Facility reviewed
- [ ] Questions remain

SCOPE OR REVIEW QUESTIONS - REFER TO THE SIGNED DOCUMENT

- [ ] **I reviewed this page and saved this packet on my own device.**

Payment Sources and Financial Readiness

Use this organizer to plan. Do not enter passwords, PINs, full bank-account numbers or payment-card numbers.

LIMIT SENSITIVE DETAILS

Record only enough information to coordinate admission. Keep account credentials and full financial records outside this packet.

EXPECTED PAYMENT SOURCES

SOURCES BEING CONSIDERED

- ☐ Private funds
- ☐ Medicaid / ALTCS
- ☐ Retirement income
- ☐ Other benefit
- ☐ Long-term care insurance
- ☐ Veterans benefits
- ☐ Family contribution
- ☐ Undecided

MONTHLY PLANNING

ESTIMATED FACILITY RATE

EXPECTED CARE ADD-ONS

OTHER MONTHLY COSTS

ESTIMATED TOTAL

AMOUNT ALREADY CONFIRMED

POSSIBLE GAP

PEOPLE INVOLVED

PRIMARY FINANCIAL CONTACT

RELATIONSHIP

PHONE

EMAIL

ADVISOR / BENEFITS CONTACT

PHONE

QUESTIONS TO CONFIRM WITH THE FACILITY

☐ **I reviewed this page and saved this packet on my own device.**

Payment Sources and Financial Readiness

Track decisions and due dates without storing account credentials.

ADMISSION COST CHECKLIST

REVIEWED

- [ ] Base monthly rate
- [ ] Medication management
- [ ] Move-in deposit
- [ ] Refund policy
- [ ] Optional services
- [ ] Level-of-care charges
- [ ] Community / entrance fee
- [ ] Room or apartment hold
- [ ] Rate-increase policy
- [ ] Discharge / notice terms

BENEFITS AND CLAIMS

PROGRAM / CARRIER

CONTACT

STATUS

NEXT ACTION

DUE DATE

PROGRAM / CARRIER

CONTACT

STATUS

NEXT ACTION

DUE DATE

PAYMENT SETUP

STATUS

- [ ] Payer confirmed
- [ ] Deposit deadline known
- [ ] Receipts / statements requested
- [ ] Billing address confirmed
- [ ] Recurring payment discussed
- [ ] Financial agreement reviewed

REMAINING QUESTIONS OR DECISIONS

- [ ] **I reviewed this page and saved this packet on my own device.**

Personal History and Preferences

Introduce the resident as a person - their story, strengths, identity and what matters most.

A SHORT INTRODUCTION

HOW WOULD THE RESIDENT LIKE TO BE INTRODUCED?

PREFERRED NAME

PRONOUNS

PRIMARY LANGUAGE

LIFE STORY

BIRTHPLACE, HOMETOWNS AND PLACES THAT FEEL LIKE HOME

WORK, SERVICE, CAREGIVING, COMMUNITY OR OTHER IMPORTANT ROLES

IMPORTANT ACCOMPLISHMENTS, TRADITIONS AND LIFE EVENTS

IDENTITY AND VALUES

CULTURE, FAITH, VALUES OR PRACTICES THE RESIDENT WANTS RESPECTED

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Personal History and Preferences

Record everyday preferences and the details that make care feel personal.

DAILY PREFERENCES

USUAL WAKE TIME

USUAL BEDTIME

BEST TIME OF DAY

MORNING AND EVENING PREFERENCES

FOOD, DRINK AND MEALTIME PREFERENCES

CLOTHING, GROOMING AND PERSONAL-SPACE PREFERENCES

STRENGTHS AND INTERESTS

TOPICS, SKILLS, HOBBIES OR EXPERIENCES THE RESIDENT ENJOYS SHARING

THINGS THAT SUPPORT INDEPENDENCE AND CHOICE

WHAT MATTERS MOST

ANYTHING STAFF SHOULD KNOW ON THE FIRST DAY

Communication Preferences

Help others understand how the resident receives information, expresses needs and joins conversations.

HOW COMMUNICATION WORKS BEST

HELPFUL APPROACHES

- [ ] Face the resident
- [ ] One idea at a time
- [ ] Allow extra response time
- [ ] Use familiar words
- [ ] Use a calm tone
- [ ] Offer written choices
- [ ] Reduce background noise
- [ ] Demonstrate the task

WORDS, PHRASES, NAMES OR CUES THAT HELP

HOW THE RESIDENT USUALLY EXPRESSES PAIN, DISCOMFORT OR NEEDS

VISION, HEARING AND LANGUAGE

GLASSES / VISUAL AIDS

HEARING AIDS / SUPPORTS

INTERPRETER NEEDS

COMMUNICATION DEVICES, BOARDS, APPS OR OTHER SUPPORTS

- [ ] **I reviewed this page and saved this packet on my own device.**

Communication Preferences

Recognize difficult moments and record the approaches that help the resident reconnect.

WHEN COMMUNICATION IS DIFFICULT

SIGNS OF FRUSTRATION, PAIN, FEAR OR OVERLOAD

TOPICS, WORDS OR APPROACHES TO AVOID

WHAT USUALLY HELPS THE RESIDENT RECONNECT

PEOPLE WHO UNDERSTAND THE RESIDENT WELL

NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE

OTHER USEFUL COMMUNICATION NOTES

Comfort and Reassurance

Capture familiar ways to help the resident feel calm, safe and respected.

WHAT FEELS REASSURING

PEOPLE, PETS, OBJECTS, PHOTOS OR PLACES THAT BRING COMFORT

MUSIC, SHOWS, READINGS, FOODS OR ACTIVITIES THAT HELP

WORDS, ROUTINES, TOUCH OR OTHER APPROACHES THAT ARE WELCOME

FAMILIAR ENVIRONMENT

LIGHTING, SOUND, TEMPERATURE, SCENTS OR ROOM SETUP THAT FEEL COMFORTABLE

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Comfort and Reassurance

Describe stress signals and the responses that have worked well.

STRESS AND DISTRESS

COMMON TRIGGERS OR SITUATIONS THAT MAY CAUSE FEAR, ANXIETY OR FRUSTRATION

EARLY SIGNS THE RESIDENT MAY NEED REASSURANCE

APPROACHES THAT HAVE WORKED WELL

APPROACHES OR TOPICS TO AVOID

WHO CAN HELP

FAMILIAR PERSON	RELATIONSHIP	PHONE

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Activities and Relationships

Record interests, social preferences and the people who matter most.

ACTIVITIES AND INTERESTS

FAVORITE ACTIVITIES NOW

PAST HOBBIES, WORK, SPORTS, MUSIC OR CREATIVE INTERESTS

SOCIAL STYLE

- ☐ Enjoys groups
- ☐ Needs quiet time
- ☐ Enjoys helping others
- ☐ Prefers one-to-one
- ☐ Likes to observe first
- ☐ Prefers familiar people

IMPORTANT PEOPLE

NAME	RELATIONSHIP	CONTACT / VISIT PATTERN
NAME	RELATIONSHIP	CONTACT / VISIT PATTERN
NAME	RELATIONSHIP	CONTACT / VISIT PATTERN

COMMUNITY AND BELONGING

FAITH, CLUBS, NEIGHBORHOODS, VOLUNTEER WORK OR COMMUNITY CONNECTIONS

WHAT HELPS VISITS AND ACTIVITIES GO WELL

Dementia and Cognitive History

Summarize known history and changes. Clinical information should be reviewed by qualified professionals and the selected facility.

SENSITIVE HEALTH INFORMATION

This page may contain diagnoses and other health details. It stays in the downloaded file, but the family must protect and share its copy carefully.

DIAGNOSIS AND EVALUATION

DIAGNOSIS / CONDITION

DATE / APPROXIMATE YEAR

DIAGNOSING PROFESSIONAL

MOST RECENT EVALUATION

EVALUATIONS, IMAGING OR RECORDS AVAILABLE

CHANGES OVER TIME

EARLIEST CHANGES NOTICED AND APPROXIMATE TIMING

CURRENT MEMORY, ORIENTATION, JUDGMENT OR PROBLEM-SOLVING CHANGES

RECENT OR SUDDEN CHANGES THAT NEED PROMPT CLINICAL REVIEW

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Dementia and Cognitive History

Record approaches, patterns and current support needs.

CURRENT SUPPORT

SUPPORT OFTEN NEEDED

- [ ] Time / date orientation
- [ ] Planning steps
- [ ] Safety awareness
- [ ] Managing finances
- [ ] Finding places
- [ ] Medication reminders
- [ ] Managing appointments
- [ ] Expressing choices

ABILITIES AND ROUTINES THE RESIDENT STILL MANAGES WELL

PROMPTS, VISUAL CUES OR APPROACHES THAT HELP

DECISION SUPPORT

DECISIONS THE RESIDENT MAKES INDEPENDENTLY AND WHERE SUPPORT HELPS

HOW CHOICES ARE BEST PRESENTED

- [ ] **I reviewed this page and saved this packet on my own device.**

Dementia and Cognitive History

Add daily patterns, known triggers and the people who can clarify the history.

PATTERNS AND CONTEXT

BEST TIME OF DAY

HARDEST TIME OF DAY

SLEEP PATTERN

KNOWN TRIGGERS FOR CONFUSION, DISTRESS OR RESISTANCE

RESPONSES THAT ARE USUALLY SUCCESSFUL

PEOPLE WHO KNOW THE HISTORY

FAMILY / CARE PARTNER

PHONE

CLINICIAN / PRACTICE

PHONE

OTHER CONTEXT OR FOLLOW-UP QUESTIONS

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Wandering, Exit-Seeking, and Safety

Describe known patterns and responses so the selected facility can complete its own assessment and safety plan.

NOT A SAFETY PLAN

This organizer does not replace immediate supervision, emergency planning, clinical assessment or a facility-specific safety plan.

KNOWN HISTORY

- [ ] No known wandering
- [ ] Becoming lost
- [ ] Unsafe area entry
- [ ] Repeated searching
- [ ] Exit-seeking
- [ ] Nighttime wandering
- [ ] Following others out
- [ ] Recent change

PLACES, PEOPLE, WORK OR ROUTINES THE RESIDENT MAY BE TRYING TO REACH

KNOWN TRIGGERS, TIMES OR SITUATIONS

EARLY SIGNS OR PHRASES THAT MAY PRECEDE LEAVING

RECENT INCIDENTS AND WHAT HAPPENED

- [ ] **I reviewed this page and saved this packet on my own device.**

Wandering, Exit-Seeking, and Safety

Record helpful responses and topics for the facility's assessment and safety plan.

HELPFUL RESPONSE

SUCCESSFUL REDIRECTION, REASSURANCE OR ENGAGEMENT APPROACHES

APPROACHES THAT INCREASE DISTRESS OR SHOULD BE AVOIDED

OTHER SAFETY CONCERNS

CONCERNS TO DISCUSS

- [ ] Falls
- [ ] Stairs
- [ ] Kitchen / appliances
- [ ] Driving
- [ ] Medication access
- [ ] Water / pool
- [ ] Smoking
- [ ] Pets

CURRENT PRECAUTIONS, EQUIPMENT OR SUPERVISION

QUESTIONS FOR THE SELECTED FACILITY

- [ ] **I reviewed this page and saved this packet on my own device.**

Daily Routine

Map the resident's familiar rhythm. Exact care needs should be reviewed with the selected facility.

MORNING

USUAL WAKE TIME

BREAKFAST TIME

MORNING MEDICINES

WAKING, TOILETING, BATHING, DRESSING AND BREAKFAST PREFERENCES

DAYTIME

LUNCH TIME

REST / NAP

BEST ACTIVITY TIME

PREFERRED ACTIVITIES, MOVEMENT, QUIET TIME AND SOCIAL RHYTHM

EVENING AND NIGHT

DINNER TIME

BEDTIME

NIGHT WAKING

EVENING ROUTINE, SLEEP CUES, LIGHTING AND NIGHTTIME SUPPORT

PERSONAL CARE AND FOOD

BATHING, DRESSING, CONTINENCE, MOBILITY, EATING OR DRINKING PREFERENCES

Packet Notes and Document Checklist

Use this final page for local tracking. Do not upload the completed packet to WrenSong.

DOCUMENTS GATHERED

LOCAL COPIES AVAILABLE

- [ ] Photo identification
- [ ] Medication list
- [ ] Advance directive
- [ ] Financial POA
- [ ] Facility agreement
- [ ] Insurance cards
- [ ] Physician assessment
- [ ] Healthcare POA
- [ ] Long-term care policy
- [ ] Other facility forms

FACILITY-SPECIFIC FOLLOW-UP

FACILITY

ADMISSIONS CONTACT

NEXT CONVERSATION

TARGET COMPLETION

MOVE-IN DATE

MISSING ITEMS OR QUESTIONS

PRIVATE NOTES

NOTES STORED ONLY INSIDE THIS DOWNLOADED COPY

BEFORE SHARING

Review the pages, remove anything the recipient does not need, and confirm the delivery method directly with the facility or professional.

- [ ] **I reviewed this page and saved this packet on my own device.**