

PERSON SUPPORTED & PRIMARY CONTACTS

Full name: _____	Preferred name: _____
Date of birth: _____	Pronouns (optional): _____
Primary caregiver: _____	Phone: _____
Backup contact: _____	Phone: _____

CRITICAL HEALTH & COMMUNICATION INFORMATION

Relevant diagnoses / health conditions _____ _____ _____ _____ Allergies / adverse reactions _____ _____ _____	Communication / support needs ☐ Uses spoken language ☐ Limited or no speech at times ☐ Needs extra processing time ☐ One question / step at a time ☐ Uses device / writing / gestures / interpreter ☐ Needs caregiver to provide baseline information ☐ Sensitive to noise / light / touch / crowding
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CURRENT MEDICATION QUICK REFERENCE

Medication	Dose	Usual time / schedule	Purpose or prescriber (optional)

USUAL FUNCTIONING & CURRENT URGENT CONCERN

Usual functioning / baseline Typical communication, movement, sleep, eating, self-care, and level of assistance. _____ _____ _____ _____	What is different now? What changed, when it began, and any immediate medical or safety concern. _____ _____ _____ _____
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For immediate danger or a medical emergency, contact 911. In the U.S., call or text 988 for suicide or mental health crisis support. This sheet is a quick-reference aid and does not replace emergency, clinical, legal, or official records.

Person Supported / Care Recipient: _____

Last Updated: _____

WHAT USUALLY HELPS / WHAT MAKES THINGS HARDER

What usually helps

- ☐ Calm, simple communication
- ☐ One person speaking at a time
- ☐ Extra processing time
- ☐ Quiet / low-stimulation space
- ☐ Predictable routine / step-by-step support
- ☐ Preferred activity / music / comfort item
- ☐ Familiar caregiver present

What may make it harder

- ☐ Several people speaking at once
- ☐ Rapid questions / repeated demands
- ☐ Loud noise / bright light / crowding / unexpected touch
- ☐ Taking away an item without explanation
- ☐ Arguing about beliefs / forcing agreement
- ☐ Separating from familiar support without explanation

HOUSEHOLD & IMMEDIATE SAFETY INFORMATION

- ☐ Pets / dependent household members need attention
- ☐ Person may leave home / become lost
- ☐ Food / medication / chemical / fire / water / electrical concern
- ☐ Important items are secured / stored separately
- ☐ Other immediate concern: _____

Specific location / safety detail (do not list passwords or full account numbers):

CARE TEAM & IMPORTANT DOCUMENTS

Primary provider / clinic: _____

Phone: _____

Mental health / specialty provider: _____

Phone: _____

Case manager / agency: _____

Phone: _____

Pharmacy: _____

Phone: _____

- ☐ Release / consent
- ☐ Advance directive / health care agent
- ☐ Power of attorney
- ☐ Conservatorship / guardianship
- ☐ No document known

- ☐ Emergency binder / folder
- ☐ Secure digital folder
- ☐ Medication list available
- ☐ Insurance / ID copy available
- ☐ Care plan / crisis plan available

CAREGIVER UNAVAILABLE / BACKUP PLAN

Immediate needs if the primary caregiver is unavailable:

Backup caregiver / contact: _____

Phone: _____

When to contact: _____

Relationship / role: _____