

PARTNER WITH ME

NAME

Personal In	fo	Hygiene	Sleep	Activity	
Call me: Former occupation:		□Observe □Assist Cues	To bed at:	_ □Walks independently _ □Needs help	
Language spoken:			Daytime naps: □yes □no Problems:	□Walker □Cane □Wheelchair	
Avoid excess questions? □Yes □No		□Shower □Bath Everyday(s)AMPM	Comfort measures:	Dresses: □self □w/assist	
I'm able to use a	call light? □Yes □No	□Dentures			
Nutrition		Toileting	Behavior/Mood	I like to	
Meals/day □Glass □Feed □Prep Tray	□Mug □Straw □Utensils	□Independent □Briefs Cues	☐ Happy ☐ Sad ☐ Irritable ☐ Impatient ☐ If I'm upset, I get	□Watch TV Favorite shows	
□Finger Food	□Snacks				
Medications		☐At night times ☐Daytime times	What helps me to calm down is	☐ Have books/magazines read to me ☐ Socialize	
☐Takes pills easil☐Mix with food Type of fluids Cues	□Crushed	times		My favorite topics	