

Date:

Name of Care Recipient include middle initial:

DOB:

SEX/RACE:

Address:

Phone:

Care Partner Completing Person-Centered Information Tool:

Address: (if different from above)

Best Contact Number:

Email:

Professional Completing Form:

Return this form to the Dementia Care Specialist at the ADRC upon completion to

register purple tube for this project.

For more information or with questions, contact the ADRC of Jefferson County 920-675-4035

Sponsored by the ADRC of Jefferson County, Tomorrow's Hope,

& Dementia Friendly Community Network



Instructions for Completing the Form

Family caregivers fill out this form with/for the person who has dementia. This tool is designed to give first responders, hospital and emergency staff the information needed to assist an individual with dementia during a difficult time. Think about things people need to know regarding <u>what works to help</u> the person, and what to avoid. It is written in the first person <u>as if the person with dementia is telling</u> the helper what they want.

Front Page Instructions:

<u>Name:</u> Legal name

I prefer to be called: Nicknames, an abbreviated name, Mr. or Mrs. and last name, a title like "Sarge" if in the military. (Something that would make them feel comfortable)

Please check appropriate box

☐ I CAN be left unsupervised

□ I CANNOT be left unsupervised

Consider if the person with dementia was left alone, would he/she be in danger? Examples: Would she wander off, does he need assistance to avoid a fall, would she get into items like soap or medical equipment, could he be confused enough by surroundings that he would become upset, nervous, and maybe yell out?

<u>Caregiver/Family Member Names/Phone Numbers:</u> List the *individual(s)*, whom it is most important to contact for *information*. This could include a *facility caregiver or home assistance caregiver*, in addition to the most knowledgeable *family member(s)*, the person who knows daily/functioning routines of the patient.

People I <u>trust</u> who <u>motivate me to cooperate</u> are: This *individual(s)* would be someone the person trusts. The use of this person's name could help calm anxiety and confusion, which could help assist medical staff with treatment, or in the case of an emergency evacuation. Example: "Tell me more about your daughter Mary" "Mary is on her way to see you" or "Would you like to call your daughter Mary?"

Things <u>that upset me</u>: In this section, try to put yourself in the person's shoes to understand her experience by being with her in the environment. Seeing things from the person's perspective helps us to understand the frustrations and confusion they experience. It also helps us to recognize that we, as helpers, must adjust the way we act, and to interact, to meet the person's needs. *Examples of what doesn't work or what to stay away from doing*: touching without informing first, telling instead of asking, too many questions, being disrespectful, yelling, or being critical. Things around the person can upset them like it being too hot or cold, loud noises, alarms or bright lights. People in uniform, (Police, EMT, Fire) could be upsetting when not having anyone familiar nearby. In addition, unmet needs can

make a person upset such as pain, needing the bathroom or feeling afraid. Include the different things that you know upset the person.

I <u>express distress</u> by: The person with dementia may have certain body language – or things he says – that indicate that he is getting upset. Examples: pacing, talking fast/loud, crying striking out, saying no, talking about a distressing memory, wringing hands, making repetitive movements or trying to leave, etc. *Whatever signals the person usually gives that indicate he or she is getting upset need to be included*.

The best ways to redirect me are: Consider what <u>works to help</u> keep the person calm. *Examples:* talking calmly, slowly or quietly, offering reassurance, eye contact, gentle touch, hand under hand, changing the subject, distracting the person's attention. Offering the person an item such as a doll, family pictures, singing a song, music, reminiscing, or talking about a trusted person, can be calming. Environmental changes that can help could be to dim lights, turn off sirens/alarms, and limit the number of people interacting with the person, music, etc. *Include things that you know can calm the person*.

The best ways to protect me or others from me: Consider things such as giving more personal space and watching safely from a distance.

Consider these items below: Think F.A.S.T.

- F Food (snacks like crackers, ice cream)
- A Activities (like TV, picture book reading, talking)
- **S Story** (favorite topics for conversation)
- T Trip (walks around with staff)

Purple Box on Front Page:

Comfort items to <u>take with</u> me: These are items that the person may need to keep them busy, calm or to provide something familiar. Examples: A doll if she likes to rock it in her arms, a favorite blanket (or other item) to comfort/hold onto, family pictures, puzzle book, whatever is needed. Also, add equipment like walkers, canes and personal items of importance to her – like a wallet, purse or keys. *What items calm and provide meaning to the person – will they be upset without the item?*

Sensory Aids Needed: This included glasses, hearing aids and dentures or other devices the person uses.

Medical Conditions: Include important things to be aware of, e.g., diabetic, pacemaker, HIV, chronic bladder infections, thickened liquids needed, stroke paralysis and where, etc. *What are important medical conditions the helpers need to know about right away*.

Allergies: Usually to medication or things like latex or nuts. Include anything that causes *severe* reactions.

Pain Areas: Indicate places that the person has chronic pain or injuries (arthritis, back pain, joint replacements, heartburn, etc.) This is VERY important because the person may not be able to tell helpers that he has pain, so they will need to monitor for it, especially if behavior gets difficult. *What painful conditions does this person have that need to be identified and treated or comforted?*

Back Page Instructions:

The best way to <u>approach</u> me is to: Examples include: *Approach from the front so*, they are aware you are coming, *walk slowly*, allow time for the person with dementia to see that you are approaching. *Call him by his preferred name*, to get his attention. *Crouch down* if she is seated, this helps her feel less threatened. *Offer your hand, greet*, and say your name – this could give you an idea whether or not the person will be receptive. *List specific preferences that hospital staff may need to know while the person with dementia is in their care*.

The best way to <u>communicate</u> with me: What things can be done to help the person with dementia express what they mean, and what can be done to help the person understand what is being communicated in return? *Examples:* make eye contact speak slowly, into the dominant ear, repeating back what they've said. Pointing, and touching gestures along with visuals like words, pictures, and facial expressions all can help the person to communicate better. Certain topics the person with dementia brings up could also mean something else. (Example) whenever she starts talking about feeding the dog that could mean she's hungry and it's time for dinner. *Include how this person communicates best*.

This helps me <u>understand</u> and <u>participate</u>: *How do you assist or help the person with a task?* Examples could be prompting by handing him the spoon, modeling a gesture of brushing his teeth, giving her a washcloth to hold while you wash her face so she can help. Asking the person for this help and showing him how to do the activity (like folding towels) can be effective. Giving the person something to keep her occupied can help avoid problems (e.g., holding something to keep the other hand occupied). Bringing up certain topics the person enjoys talking about can encourage the person to talk. *What things can be done to help the person participate or do for herself?*

While I am hospitalized...

This section is to help staff members who work in the hospital to understand and get to know the person with dementia. Questions are about <u>day to day things that are important to the person</u>. The information here is used to make the person more comfortable, experience less stress, and keep a familiar routine.

How to give me Medications: Indicate if person can self-administer, needs to be given one at a time, supervised, crushed in apple sauce, etc.

My daytime/night time routine preferences: The person with dementia may have specific requests or routines, *examples include:* sleep late, get up early, bathing morning or night, specific meal time or bathroom requests. What does the person need in order to feel comfortable or "ready" to start the day? Like reading a newspaper, having his teeth in, wearing a bathrobe before the doctor comes in. *Include schedule/order person does things during day*.

Comfort Measures: Consider items such as pillows, blankets, and music

Things I <u>enjoy</u> (music/TV shows/food/activities, etc.): It is important to keep the person with dementia busy with things that help him relax, and make him happy. If the person cannot be alone there may be a companion to sit with who does things the person enjoys. Are there favorite snacks, items like a doll to hold, family photo book, types of music, TV shows or her favorite movie? Does the person like hand or shoulder massages, playing cards, puzzles, being read to, or other things? Also, consider topics, items, or

activities that someone can use to distract or refocus the person's attention away from something unpleasant.

Special notes: This section is to be completed with important information that is not listed above. Examples could be, checking the napkins for dentures before throwing anything away, always give pills with milk, sing "you are my sunshine" to change her mood, alarms will get person very upset, must have rosary at bedtime, etc.

How to Use this Form

When you have completed the form consider having the hospital, doctor's office or a relative keep a copy on file, and make sure to put the form in a your purple tube and place in the refrigerator for First Responders to see.

Give the tube to the Emergency Responders and/or staff in the ER

You can also make copies for caregivers that are new to the person, such as relatives providing care or someone providing in home services; or when the person is attending day services, moving to another location, or staying with someone else for respite.

Attachments:

1. <u>Attach a list of medications with prescribers and providers as well as a diagnosis</u>, and other information that would be important to know, that perhaps didn't fit on the form.

2. Attach a recent picture of the person.



Providing important information for first responders in Jefferson County for those impacted by dementia. Call 920-675-4035 for more information

Thank you for your interest in the Jefferson County Purple Tube Project. This project is a collaboration between our county's first responders, ADRC of Jefferson County, Tomorrow's Hope, and our county-wide Dementia Friendly Community Network. As the number of people with Alzheimer's disease and related dementia grows, so does the need for positive emergency interventions. The Jefferson County Purple Tube Project is free and assists families coping with dementia to develop a crisis/safety plan which includes information such as contact people, brief medical history, healthcare powers of attorney and ways to best interact with the person living with dementia.

It is difficult in a time of crisis or a time of feeling overwhelmed to figure out what to do next. When a medical or behavioral emergency occurs, we want you to feel confident in your response and the information you have ready to share with those that first respond (Law Enforcement, Emergency Medical Services, etc.).

We will work with you to complete the Person-Centered Information Tool, provide a purple tube to keep the information safe and ask that you store that information in your refrigerator, so the first responders know where to look for the information. 911 dispatch will have access to a Purple Tube database which will alert them that they are responding to a home in which has someone living with dementia inside.

If your loved one requires transport to the hospital, they will take the contents of the tube with them to share with the local emergency room staff.

- 1. Complete the person-centered information tool
- 2. Add additional items such as photo and/or Power of Attorney paperwork
- 3. Place information in purple tube (Roll it up to fit)
- 4. Place tube in your primary refrigerator
- 5. Place purple sticker on door jamb (near eye level) of each door in which first responders may enter
- 6. Update/review contents every six months or after a significant change

Our hope is that you will never need to use the purple tube; but we want you to be confident that if a "crisis situation" does occur; helpful information is available quickly.

Please call 920-675-4035 for more information or assistance with the

FREE Purple Tube Project.

Sponsored by the ADRC of Jefferson County, Tomorrow's Hope, & Dementia Friendly Community Network

Consumer #:____

JEFFERSON COUNTY HUMAN SERVICES AUTHORIZATION FOR DISCLOSURE OF INFORMATION

l,,	Date of Birth	_, authorize c	lisclosure between:	Date range of information to be
disclosed: to				
Name of consumer or	individual			
Jefferson County Human Services 1541 Annex Road Jefferson, WI 53549 Program(s):	 ☐ TO RELEASE TO ☐ TO RECEIVE FROM ☑ TO RELEASE TO A ☑ VERBAL COMMUNICATION 	AND FROM NICATION	Including Law En Medical Personne Room Staff, Jeffer	Emergency Responders: forcement, Emergency I, Fire Protection, Emergency rson County Crisis Aging and Disability Resource n County
The disclosure of the following area	ific information is antherit-	ad		
The disclosure of the following specific information is authorized. Alcohol and Drug Abuse Records Mental Health Records Psychiatric Records Intoxicated Driver Records Birth to Three Records Child Protective Services Records Children's Long Term Waiver Juvenile Records (Indicate type below) Child Protective Services Records Records Specific Information: Contents of Purple Tube				
The Purpose of this Disclosure is:				
Imer Purpose of this Disclosure is: Further Medical Care Insurance Eligibility/Benefits Legal Investigation or Action At the Request of the Individual				
NOTICE: Y	YOUR RIGHTS WITH R	ESPECT T	O THIS AUTHOR	IZATION
Right to Receive a Copy of this Auth			voke this Authorizati	
I understand that once I sign this Authoriz	-	I understand that I have a right to revoke this authorization at any time. If I revoke this authorization I must do so in writing and to the appropriate		
to do, I will be provided with a copy of the signed form.		department/facility that was authorized to release information. I understand		
Right to Refuse to Sign this Authorization I understand that I may refuse to sign this authorization. I understand that Jefferson County Department Human Services will not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign or refuse to sign this authorization. Jefferson County Department Human Services may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of a valid authorization for the disclosure of the protected health information to a		in response to reliance upor my insurance contest a clai Jefferson Cor Right to Kr I understand	o this authorization or when this authorization. I under company when the law im under my policy. The unty Human Services Deprovement that once information	is disclosed pursuant to this signed
third party.		information r	nay not apply to the recip	45 CFR Part 164) protecting health pient of the information, therefore may
The following notice shall accompany all from records protected by federal confider in this record that identifies a patient as h through verification of such identification information is being disclosed or as other sufficient for this purpose (see § 2.31). The with a substance use disorder, except as p under DHS 92.05 and 92.06.	ntiality rules (42 CFR part 2). The having or having had a substance by another person unless further wise permitted by 42 CFR part 2. he federal rules restrict any use o rovided at §§ 2.12(c)(5) and 2.65	drug and alcoh he federal rules e use disorder e disclosure is e: . A general auth of the informati 5." The patient	ol abuse consumers: "The prohibit you from making ither directly, by referent expressly permitted by the horization for the release on to investigate or pros- has the right of access to	ng any further disclosure of information tee to publicly available information, or written consent of the individual whose of medical or other information is <i>NOT</i> ecute with regard to a crime any patient medical record information as provided
This authorization shall expire 1(on is earlier.	e) year from the date it is sig	gned, or on t	he following date	, or event, whichever
SIGNATURES				

Signature of consumer (Minors included)	Date:
Signature of legally responsible person or personal representative (if required)	Date:
Please explain representative's authority to act on behalf of consumer:	
Electronic Copy: Declined Reason: Issued To be Mailed Date Mailed	Authorization for Disclosure 3/2023

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Jefferson County Dementia Crisis Response Person-Centered Informational Tool

Name:	
I prefer to be called:	Comfort Items to take with me:
Address:	
Phone Number:	
Please check appropriate box:	Sensory Aids Needed (Glasses,
I CAN be left unsupervised I CANNOT be left unsupervised	Hearing Aids, etc.):
I live with:	
Caregiver/Family Member Names and Phone Numbers:	Medical Conditions:
People I trust who motivate me to cooperate are (name/phone number):	Allergies;
	Pain Areas:
Some of <u>my personal preferences</u> are: (such as likes hugs versus Dislikes hugs or likes socks and shoes on versus barefoot, etc.)	
	*Remember to attach medication list
If I am upset / being aggressive or combative you SHOULD / SHOULD NOT approach me (circle one)	
Things that <u>upset me or trigger me</u> :	
l <u>express distress</u> by:	

The best ways to <u>redirect me</u> are: (such as talk about my past, use photos, sing, offer a snack, take me to my room, other coping skills, etc.)

The best ways to <u>protect me or others from me</u> are: (such as give me more personal space, watch safely from a distance, distract me, move others away from me, have staff / police close to me but at least an arm's length away etc....)

*Give me choices

*Allow me to be right by agreeing with me

*Be aware of how your words and behavior affect me

- * Validate my feelings to show me you understand
- *Keep your questions to me short and simple, use gestures *Redirect my attention to something different if I'm upset
- * Give me time to respond, don't rush, SMILE!

*Use the word "WE" so we can work together

The best way to <u>approach and communicate</u> with me: (such as call me by name, face me directly, make eye contact, use short sentences, etc.)

The best way to help me <u>understand and participate</u>: (such as use gestures, slow down, smile, repeat when necessary in a respectful manner, etc.)

Choosing my meals

Opening containers

Cutting my food

I am at risk for choking

While I am hospitalized, I need assistance with: (check all that apply)

- Using the nurse Call Button
- Asking for "as needed" medications
- Using hospital phone
- Using cell phone

How to give me medications:

My daytime routine preferences are:

My nighttime routine preferences are:

Comfort measures that I prefer (pillows, blankets, sleep with light on or music playing, positioning, etc.):

Things I enjoy, my strengths, needs, important people in my life, favorite foods, activities, TV shows (type), music (what types), hobbies (past & present) what I did for a living (what shift did I work) etc:

I need a straw I need help in bathroom I need help bathing/washing up Other_____

For Caregivers:

Specific concerns that the person or people providing support and care may have (history of aggression toward self or others? Acces	s to
any weapons? Has law enforcement been involveddid that help or make it worse?):	

If or when a respite or alternative placement is necessary, what would be appropriate options (any relatives? What is the preferred hospital if needed?)

Signature of Person Filling out Form:	Date:
If the person signing is a representative, please indicate your representation such your relationship to the person listed on the form	as Power of Attorney, Guardian etc and
Address:	Phone: ()
(When you sign this form, you are authorizing it to be used by those you initial: Jefferson County Sheriff's Office,Local Police Department,	Jefferson County Human Services and Health Department, _Local EMS/First Responders,Local Hospital,Other

(Adapted from the Person Centered Dementia Care Mentors Alliance of Jefferson County, Wisconsin USA)



Date:

Name of Care Recipient include middle initial:

DOB:

SEX/RACE:

Address:

Phone:

Care Partner Completing Person-Centered Information Tool:

Address: (if different from above)

Best Contact Number:

Email:

Professional Completing Form:

Return this form to the Dementia Care Specialist at the ADRC upon completion to

register purple tube for this project.

For more information or with questions, contact the ADRC of Jefferson County 920-675-4035

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Consumer #:____

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The Purpose of this Disclosure is: Further Medical Care Insurance Eligibility/Benefits Legal Investigation or Action At the Request of the Individual				
NOTICE: YO	OUR RIGHTS WITH R	ESPECT 1	TO THIS AUTHOR	RIZATION
 Right to Receive a Copy of this Authorization I understand that once I sign this Authorization, which I am not required to do, I will be provided with a copy of the signed form. Right to Refuse to Sign this Authorization I understand that I may refuse to sign this authorization. I understand that Jefferson County Department Human Services will not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign or refuse to sign this authorization. Jefferson County Department Human Services may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of a valid authorization for the disclosure of the protected health information to a third party. 		I understand revoke this department/ that the revo in response reliance upo my insurand contest a cla Jefferson Co Right to K I understand authorization information not prohibit	authorization I must of facility that was authori ocation will not apply to to this authorization or wo on this authorization. I un ce company when the la aim under my policy. The ounty Human Services D now the Potential fo d that once information n, federal privacy law may not apply to the read the recipient from re- di	evoke this authorization at any time. If I lo so in writing and to the appropriate ized to release information. I understand information that has already been released where the department/facility has acted in inderstand that revocation will not apply to aw provides my insurer with the right to he right to revoke is also discussed in the Department Notice of Privacy Practices. r Re-disclosure n is disclosed pursuant to this signed (45 CFR Part 164) protecting health cipient of the information, therefore may isclosing it without my authorization.
The following notice shall accompany all dis from records protected by federal confidenti in this record that identifies a patient as hav through verification of such identification by information is being disclosed or as otherwis sufficient for this purpose (see § 2.31). The with a substance use disorder, except as pro under DHS 92.05 and 92.06. This authorization shall expire 1(one) is earlier.	ality rules (<i>42 CFR part 2</i>). The ing or having had a substance another person unless further se permitted by 42 CFR part 2. federal rules restrict any use of vided at §§ 2.12(c)(5) and 2.65	drug and alcol ne federal rule use disorder disclosure is o A general au f the informat The patient	nol abuse consumers: "T es prohibit you from mai either directly, by refere expressly permitted by the thorization for the release ion to investigate or pro- c has the right of access to	This information has been disclosed to you king any further disclosure of information ence to publicly available information, or he written consent of the individual whose se of medical or other information is <i>NOT</i> ossecute with regard to a crime any patient to medical record information as provided

SIGNATURES

Signature of consumer (Minors included)	Date:	1
Signature of legally responsible person or personal representative (if required)	Date:	ī
Please explain representative's authority to act on behalf of consumer:		
		Authorization for Disclosure 3.

Electronic Copy: Declined Reason: _____ Issued To be Mailed Date Mailed _____

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Jefferson County Dementia Crisis Response Person-Centered Informational Tool

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The best ways to <u>protect me or others from me</u> are: (such as give me more personal space, watch safely from a distance, distract me, move others away from me, have staff / police close to me but at least an arm's length away etc...)

∗Give me choices
*Allow me to be right by agreeing with me
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- *Keep your questions to me short and simple, use gestures *Redirect my attention to something different if I'm upset
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Choosing my meals

Opening containers

I am at risk for choking

O Cutting my food

While I am hospitalized, I need assistance with: (check all that apply)

- Using the nurse Call Button
- Asking for "as needed" medications
- Using hospital phone
- Using cell phone

How to give me medications:

My daytime routine preferences are:

My nighttime routine preferences are:

Comfort measures that I prefer (pillows, blankets, sleep with light on or music playing, positioning, etc.):

Things I enjoy, my strengths, needs, important people in my life, favorite foods, activities, TV shows (type), music (what types), hobbies (past & present) what I did for a living (what shift did I work) etc:

I need a straw
 I need help in bathroom
 I need help bathing/washing up
 Other ______

For Caregivers:

Specific concerns that the person or people providing support and care may have (history of aggression toward self or others? Ac	cess to
any weapons? Has law enforcement been involved –did that help or make it worse?):	

What are stressors, triggers	, coping plans and sup	port for the household members?
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If or when a respite or alternative placement is necessary, what would be appropriate options (any relatives? What is the preferred hospital if needed?)

Signature of Person Filling out Form:	Date:
If the person signing is a representative, please indicate your representation such as F your relationship to the person listed on the form	Power of Attorney, Guardian etcand
Address:	Phone: ()
(When you sign this form, you are authorizing it to be used by those you initial:	Jefferson County Human Services and Health Department

_____Jefferson County Sheriff's Office, _____Local Police Department, ______Jefferson County Sheriff's Office, _____Local Police Department, _____Local EMS/First Responders, _____Local Hospital, ____Other