

Communication

How I best communicate (verbal, gestures, etc.): _____

Hearing aids: Yes No

Glasses: Yes No

Preferred language: _____

Mobility & Assistance

How I get around: _____

Do I use assistive devices? Yes No

If yes, please specify: _____

Sleep Preferences

What helps me sleep: _____

Nighttime routines: _____

Personal Care Needs

Assistance with bathing/dressing: _____

Toileting needs: _____

Any sensitivities or preferences: _____

Medications

Any issues taking medications (difficulty swallowing, refusal, etc.): _____

Dietary Needs

Dietary restrictions or preferences: _____

Allergies: _____

Advance Care Planning

Do I have an Advance Care Plan? Yes No

Power of Attorney (POA): Yes No

Name of POA: _____

Other directives: _____

Additional Notes for Care Team

(Anything else that helps staff provide comfort and reduce stress)

Purpose of This Form:

This document serves as a tool for healthcare providers to understand the person behind the diagnosis, reduce anxiety caused by unfamiliar environments, and provide compassionate, personalized care.

I/We agree to share with health care professionals caring for me and/or my/our loved one named on this form.

Alzheimer's/Dementia Patient Support Profile



Alzheimer's / Dementia Patient Support Profile

To Support Comfort During Transitions From Home To Hospital Or Care Facility

Patient Information

Full Name: _____

Preferred Name/Nickname: _____

Date of Birth: _____

Current Address: _____

Where I am from (town/state/country): _____

How long I have lived there: _____

Completed By

Name of Person Completing Form: _____

Relationship to Patient: _____

Phone Number: _____

Email: _____

Caregiver Signature: _____

Date: _____

Important People in My Life

(Include family, friends, caregivers, and pets)

Name/Relationship: _____

Name/Relationship: _____

Pets (names/types): _____

Personal Background

Family history and meaningful relationships:

Important Life Events and Memories

Cultural Background

Faith/Spiritual/Religious beliefs (if any): _____

What Matters Most to Me

- Family contact
- Familiar objects (photos, blankets, etc.)
- Quiet environment
- Music: _____
- Other: _____

Hobbies, Interests & Achievements

Hobbies/interests: _____

Past accomplishments or proud moments:

Job history / career: _____



Places I Have Lived or Spent Significant Time

Daily Routine (Very Important)

Typical wake-up time: _____

Meal times: _____

Bedtime routine: _____

Activities I enjoy during the day: _____

Things That May Upset or Worry Me

What Helps Me Feel Calm or Safe

(When I am anxious or confused):

