Alzheimer’s Care Plan

Patient Information
Full Name:
Date of Birth:
Gender:
Patient ID:
Contact Number:
Email Address:

OPTIMIZE FUNCTION AND QUALITY OF LIFE

Assess the cognitive and functional status.	
Identify preserved capacities/preferred activities; encourage socializing and participating in activities.	
Refer to an occupational therapist and/or physical therapist to maximize independence.	
Encourage lifestyle changes that may reduce disease symptoms or slow their progression (e.g., establish routines for a person with disease and care partner).	
Work with the health care team to appropriately treat conditions that can worsen symptoms or lead to poor outcomes, including depression, alcohol/substance use, hearing loss, and existing medical issues.	

MANAGE CO-MORBID/CHRONIC CONDITIONS

As dementia progresses, modify treatment goals and thresholds.	
Create a plan of care for chronic conditions (e.g., CHF, diabetes) to prevent potentially harmful hospitalization, and minimize risks (e.g., infection, delirium).	
Schedule regular health care provider visits, and encourage care partner presence and involvement.	
Ensure the person living with Alzheimer's and care partner has the knowledge and skills needed to carry out the care plan.	

ASSESS SAFETY AND DRIVING

Continue to discuss safe driving. • **Refer to a driving rehabilitation specialist for clinical and/or in-vehicle evaluation.** • **Report an at-risk driver**	
Continue to discuss home safety and fall risk. • **Refer to an occupational therapist and/or physical therapist, if indicated, to address fall risk, sensory/mobility aids, and home modifications.**	

FACILITATE ADVANCE CARE PLANNING AND END-OF-LIFE CARE

Recommend the patient completes their healthcare advance directives, DPOA for healthcare, and DPOA for finances. • **This becomes even more important to complete in persons with a new diagnosis of dementia or MCI. The ability to imagine future outcomes and name preferences for care, especially in writing, is lost early.** • **A dementia directive is a specific document that may be used as a supplement or addendum to a standard advance directive, which may not adequately cover dementia.**	
Continue to discuss care goals, values, and preferences with a person with the disease and family. • **Begin discussion early in the disease and continue throughout the illness. Include information about the disease process and end of life, to help manage expectations and set appropriate goals of care.** • **Before the advanced stages of dementia, a person may still maintain the ability to say what is important to them in verbal interactions, especially with those they trust.**	
Complete POLST form early in the disease and routinely re-evaluate / modify the plan of care as appropriate. • **As dementia progresses, medical interventions and medications that were once beneficial may have deleterious effects in persons with advanced dementia, particularly for those approaching end of life.** • **POLST forms should be updated to reflect evolving goals of care.** • **Continued communication between caregivers, family members, and providers is essential to ensuring that these goals of care are upheld.**	

ASSESS CARE PARTNER / FAMILY CAREGIVER NEEDS

Identify care partners and assess their health and emotional well-being.	
Identify care partners in their own medical records (if accessible).	
Encourage self-care of the care partner. • **Offer suggestions to the care partner for maintaining their health and well-being. Include care partner support services (e.g., counseling, support groups, respite) in the care plan for the person with dementia.**	

Physician's Notes and Recommendations

Physician's Signature
Date: