

# Triggers & Warning Signs

Version date: \_\_\_\_\_

For anyone spending time with the person I support. Fill in by hand and update it whenever things change. Follow the current care plan first.

Name of the person I support: \_\_\_\_\_

Emergency contact & phone: \_\_\_\_\_

Doctor or care team phone: \_\_\_\_\_

## THINGS THAT CAN UPSET OR OVERWHELM THE PERSON I SUPPORT *(check all that apply)*

- |                                                    |                                                      |                                              |
|----------------------------------------------------|------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Loud noise or TV          | <input type="checkbox"/> Crowds or visitors          | <input type="checkbox"/> Being rushed        |
| <input type="checkbox"/> Bathing or dressing       | <input type="checkbox"/> Unfamiliar people or places | <input type="checkbox"/> Changes in routine  |
| <input type="checkbox"/> Late afternoon or evening | <input type="checkbox"/> Being tired                 | <input type="checkbox"/> Hunger or thirst    |
| <input type="checkbox"/> Pain or discomfort        | <input type="checkbox"/> Needing the bathroom        | <input type="checkbox"/> Too hot or too cold |
| <input type="checkbox"/> Being corrected           | <input type="checkbox"/> Too many choices            | <input type="checkbox"/> Other: _____        |

Specific people, places, topics, or sounds: \_\_\_\_\_

## EARLY SIGNS THEY ARE GETTING UPSET

- |                                                   |                                                      |                                            |
|---------------------------------------------------|------------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Pacing or restlessness   | <input type="checkbox"/> Repeating questions         | <input type="checkbox"/> Raised voice      |
| <input type="checkbox"/> Going quiet or withdrawn | <input type="checkbox"/> Wringing hands or fidgeting | <input type="checkbox"/> Asking to go home |
| <input type="checkbox"/> Refusing help            | <input type="checkbox"/> Tearful                     | <input type="checkbox"/> Other: _____      |

## WHAT USUALLY HELPS *(what works for the person I support)*

| When this happens | Try this first | Then try |
|-------------------|----------------|----------|
|                   |                |          |
|                   |                |          |
|                   |                |          |
|                   |                |          |
|                   |                |          |

## THINGS TO AVOID

- ☐ Arguing or correcting
- ☐ Raising your voice
- ☐ Crowding their space
- ☐ Rushing
- ☐ Restraining or blocking

## CALMING PHRASES, MUSIC, OR ACTIVITIES

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**Stay calm and kind. Explain what you are doing, ask before helping, and give them time. Their behavior is often a way of telling us something.**

**Free to print and share.** From Lighthouse by Dragonfly, an iPhone app for organizing care information, medications, and appointments. [lighthousebydragonfly.com](https://lighthousebydragonfly.com)  
*Private health information. Store securely.*



More free  
caregiver tools  
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**WHAT IS USUAL FOR THE PERSON I SUPPORT** *(established needs, not an emergency)*

Usual mood and energy: \_\_\_\_\_

Usual sleep pattern: \_\_\_\_\_

Usual confusion or memory level: \_\_\_\_\_

Usual walking and balance: \_\_\_\_\_

Other usual behaviors that may look worrying but are normal for them: \_\_\_\_\_

**NEW OR GRADUAL CHANGES: CALL THE DOCTOR OR CARE TEAM**

A change from their usual self can be a sign of pain, infection (such as a urinary infection), dehydration, constipation, or a medication side effect. Write down what you see and when it started.

- |                                                   |                                                   |                                                     |
|---------------------------------------------------|---------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> More confused than usual | <input type="checkbox"/> New agitation or fear    | <input type="checkbox"/> Sleeping much more or less |
| <input type="checkbox"/> Eating or drinking less  | <input type="checkbox"/> Bathroom changes or pain | <input type="checkbox"/> Fever                      |
| <input type="checkbox"/> New unsteadiness         | <input type="checkbox"/> Seeing or hearing things | <input type="checkbox"/> Other:                     |

Who to call first and phone: \_\_\_\_\_

**SUDDEN OR SERIOUS CHANGES: CALL 911**

- Signs of stroke: face drooping, arm or leg weakness, trouble speaking or understanding, sudden vision or balance trouble. Note the time symptoms began.
- Chest pain, trouble breathing, or very hard to wake or unresponsive.
- A fall with a head injury, severe pain, or they cannot get up. Do not move them unless they are in danger.
- A seizure lasting more than 5 minutes, or a first seizure.
- They are a danger to themselves or others and you cannot keep everyone safe.
- They are missing. Search nearby for no more than 15 minutes, then call 911.

Tell 911 about (diagnosis, communication needs, allergies): \_\_\_\_\_

**RECENT CHANGES LOG**

| Date | What changed | Who was told / what they said |
|------|--------------|-------------------------------|
|      |              |                               |
|      |              |                               |
|      |              |                               |
|      |              |                               |
|      |              |                               |

**This sheet does not replace the care plan or medical advice. When unsure, call the care team. In an emergency, call 911.**

