



Name: _____

Address: _____

Telephone: _____

Emergency contact name(s): _____

Emergency contact number(s): _____

Days for which a companion may be required

Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Hours and/or projected length of shifts: _____

Time(s): Day Afternoon Night Overnight All

Reason for companionship

Recent surgery Recent illness Long-term illness Pregnancy Shut-in

Recent birth Respite Special needs Mobility Age

Other: _____

Challenges

Eyesight Mobility Memory Muscle control

Language Diet Hearing

Other: _____

Service(s) Required

Companionship Housekeeping Meal preparation Travel

Other: _____

What type of companionship is preferred

Conversation Reading Walks Games Respite

Other: _____

Are there pets on-site: Yes No

Is the client a smoker: Yes No

Dietary Requirements

Please list any food allergies: _____

Dietary restrictions: _____

Meal preferences: _____

Housekeeping Services

Laundry Vacuuming Mopping Cleaning

Dishes Windows Kitchen Bathroom

Other: _____

Other services that may be required

Transportation Lawn care Snow removal Grooming/personal care

Medical care Hair care Emergency alarm

Date: _____ Representative: _____