



# COVID-19 Care Plan for person with a disability

## Use this plan if you live with a disability

It is important to plan in case you get COVID-19 and need to stay at home.

Most people with up to date vaccinations who get COVID-19 experience only mild symptoms and can care for themselves at home with support from their GP. Other people may need to go to hospital.

A COVID-19 Care Plan (Care Plan) includes important information about you and your health and includes a plan for the care of your pets, should you need to go to hospital. Complete it now and if you have to go to hospital, take it with you.

You can share this plan with:

- your GP
- your care team, family or support person
- hospital staff – nursing and medical staff should read this before they do any interventions with you, and a copy should be placed in your notes
- other health workers.

[COVID-19 Care Plan for adults](#) and [COVID-19 Care Plan for parents/carers and children](#) can be found on [HealthyWA](#).

## How to use this plan

- Complete and print your Care Plan
- Keep it somewhere easy to find, like on your fridge or near your bed
- If you get COVID-19 and need to be hospitalised, use this COVID-19 Care Plan.





**Things you need to know about me**

My photo

**I live with:**

- |                        |                         |
|------------------------|-------------------------|
| Family                 | Supported accommodation |
| Alone                  | Private facility        |
| Other unrelated people | In public housing       |
| Paid carer             | Residential aged care   |
| Unpaid carer           | Other                   |
| Details                |                         |

**Best contact person/s** (Next of kin, or other)

Name	Relationship to patient	Phone number
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**Enduring Power of Attorney**

Yes      No

Name	Relationship to patient	Phone number
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## Things you need to know about me

### My health

#### I have the following health documents:

Advance Care Plan document

Advance Health Directive/Statement of choice

Resuscitation plan

Adult Guardianship / Enduring Power of Attorney

None

Other

Please attach copies of any documents to this COVID-19 Care Plan

### Medical conditions

(Are you pregnant, obese, do you have diabetes or a heart, lung or kidney condition?)

Yes      No      Unsure

Details

### Medical history and treatment plan

(Major surgeries, medical interventions and current care plans)



Things you need to know about me

**My disability**

**Disability** Please tick all appropriate boxes

- Intellectual impairment
- Specific learning (other than intellectual)
- Autism spectrum disorder (including Aspergers)
- Other
- Deaf or blind
- Physical disability
- Acquired brain injury

**Level of support I require**

- Full support (require full care for all day-to-day activities)
- Partial support dependent (require intensive assistance but can do some activities for myself – cannot be left alone)
- Partial support with independence (require some assistance and can do some activities – can be left alone)
- Limited support (require some assistance but mostly independent)
- Occasional support (live independently with some support)
- Completely independent
- Other

**Disability support needs** (special needs related to your disability)

Communication aids, mobility aids, technology to assist deaf and hard of hearing and vision impaired, wheelchair or other support needs



## Things you need to know about me

**Mobility and falls risk** (I walk with assistance, I need to be wheeled in a wheelchair or other)

**How I use the toilet** (I need continence aids, help to get to the toilet or other)

### Disability support documents/plans

Behaviour Support Plan

Communication Plan

Other

Please attach support plans to this COVID-19 Care Plan.

### I am currently receiving treatment for cancer

Yes      No

If yes, please provide details of the type of cancer and type of treatment.



**Things you need to know about me**

**My medications**

Medication name	Purpose	Dose	Frequency/times to be given
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Medications current as of:

**Allergies or adverse reactions**

**Allergy name**

Medication or treatment

Allergy care plan provided

**Allergy name**

Medication or treatment

Allergy care plan provided



**Things you need to know about me**

**Allergy name**

Medication or treatment

Allergy care plan provided

**Allergy name**

Medication or treatment

Allergy care plan provided

**Allergy name**

Medication or treatment

Allergy care plan provided

Please attach allergy care plans to this COVID-19 Care Plan.

**Current health care plan**

(Mental health care plan or plan for the treatment of an existing health condition, or other)

Yes      No

Name of care plan	What it is for	Doctor, specialist or healthcare service or agency that supports you	Phone number
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## Things you need to know about me

Other health conditions

Special dietary considerations

**Risk of choking or dysphagia** (eating, drinking or swallowing difficulties)

I have difficulties eating, drinking or swallowing

Yes      No

Details



## Things you need to know about me

How I eat (My food is cut up, pureed, I need help with eating or other)

How I drink (I drink small amounts, use a straw or other)

Food and drink dislikes



**Things you need to know about me**

**Other information**

My doctor (GP) and other services/professionals involved in my care

Name	Occupation/role	Phone number
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**Regular activities/commitments**

(I attend occupational therapy, music, social groups, workshops or other)

Activity	Day	Time	Phone number
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**Things you need to know about me**

My cultural background and spiritual beliefs (My ethnicity, spiritual beliefs or other)

**Language**

- |           |            |
|-----------|------------|
| English   | Samoan     |
| Cantonese | Nyoongar   |
| Mandarin  | Vietnamese |
| Hindi     | Arabic     |
| Spanish   | Other      |
| Details   |            |

I need a translator

Yes      No



**Things you need to know about me**

**My communication style**

I can usually communicate verbally

Yes      No

This helps me talk to you	This helps me to understand you
My communication system (please name the system below in Other)	Short simple sentences
	Simple words
Symbols	Concrete examples
Pictures	Diagrams or pictures
Gesturing	Check that I understood
Facial expressions	Ask me to explain it
Simple words	Ask my carer/supporter to explain it to me
When you wait for me to respond	Use real objects
My carer/supporter	Give me a demonstration

Other

Please communicate with me by
Speaking directly to me
Taking time to tell me
Waiting for me to respond
Writing notes in my care plan
Knowing I cannot talk but can hear and understand



## Things you need to know about me

### Normal behaviours for me

(Sometimes I grunt or rock backwards and forwards, or other, but this is normal for me)

### Concerns or worries I have

(Fear of dark, fear of being left alone, or other)

### How to know I am in pain

(I may rock back and forth in my chair, or other)

### How to keep me safe

(Bed rails, support with challenging behaviour, or other)



**Useful things to know about me**

**My comfort items**

(Things that reduce my anxiety)

**Sleeping**

(Sleep routine)

**My support person/s and their role**

Name	Relationship to patient	Their role in my care	Phone number
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**My likes and dislikes**

**Things I like that make me feel comfortable**

(Being talked to softly, not being left alone, or other)

**Things I dislike that make me feel uncomfortable**

(Loud noises, being left alone, or other)

**Other information I would like to share**

(My routine, or other)

**Notes or more information**



## Complete this section if you test positive to COVID-19

Date symptoms started

Date of positive COVID-19 test

Next of kin advised                      Yes              No

**Did you test positive using a rapid antigen test (RAT)?** Yes              No

If yes, register your positive RAT result on the [HealthyWA](#).

### WA COVID Care at Home

WA COVID Care at Home delivers home monitoring care for COVID-19 positive people who require it due to having risk factors that put them at greater risk of requiring hospitalisation (such as age, severity of symptoms, medical history and social factors).

Have you registered for the free WA COVID Care at Home? Yes              No

See more information about WA COVID Care at Home and register online at [HealthyWA](#).

### Monitor my COVID-19 symptoms

To monitor your COVID-19 symptoms, print the symptoms diary [here](#)

### GP, specialist or healthcare worker who will help look after you

If you test positive for COVID-19, you may need to seek support from your GP, treating specialist or healthcare worker. Provide their contact details below.

#### Name

Title (e.g. GP, cardiologist)

Phone number

Address

Email address (if relevant)

#### Name

Title (e.g. GP, cardiologist)

Phone number

Address

Email address (if relevant)



**I have pets/livestock in my care** Yes      No

**If I need to go to hospital with COVID-19, I would like the following people to care for my pets/livestock** (in order of preference)

**1. Name**

Address

Phone number

Discussed with carer?      Yes

**2. Name**

Address

Phone number

Discussed with carer?      Yes

**3. Name**

Address

Phone number

Discussed with carer?      Yes

**Notes and other information I would like to share**

Name

Signature

Date (dd/mm/yyyy)

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This document can be made available in alternative formats on request.

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