

Caregiver Responsibilities Agreement: Allogeneic Transplant

Patient Name (Printed)

Patient Medical Record Number (MRN)

A successful allogeneic (donor) bone marrow/stem cell transplant requires commitment not only from the patient and medical team, but from the patient's support system as well. Each patient requires a **minimum** of one full-time primary caregiver and one secondary caregiver to act as back-up and/or provide general relief should the primary caregiver need (a total of 2).

A **caregiver** is a responsible adult family member or friend who is able and willing to provide physical care, observation, reliable transportation and emotional support throughout the transplant process. Private duty caregivers/home care agency staff as well as alternate care settings such as nursing homes, assisted living centers or group homes are **not** acceptable caregiver options. The caregiver or alternate must be available as needed during the entire transplant process, including but not limited to:

- pre-transplant evaluation
- education sessions
- weekly visits during hospital admission
- full-time following discharge from the hospital

Being a caregiver for a transplant patient is a vital role. Please consider the following list of responsibilities and requirements from the transplant center before agreeing to this commitment.

- I/we will be available 24 hours a day upon discharge, **for about 3 months or for as long as medically required by the BMT doctor.**
- I will carry a cell phone with me at all times.
- I/we will reside with the patient, within 100 miles of Michigan Medicine, for **about 3 months or for as long as required by the BMT doctor.** If the patient's primary residence is not within 100 miles, I/we will arrange temporary lodging post-transplant in a 100-mile radius preferably in the Ann Arbor area.
- I/we will attend discharge training (required by the transplant center) to learn intravenous (IV) care.
- I/we will review the transplant materials and treatment instructions provided by the transplant center.
- I/we will ask the transplant center staff questions and be available for communication as needed.
- I/we will provide the patient's transportation to all appointments.

- I/we will be with the patient at all appointments (**early morning** appointments are standard).
- I/we will have an understanding of the patient's medications, assist with administration as needed and keep a log.
- I/we will follow the transplant center instructions and precautions regarding infection prevention.
- I/we will coordinate food preparation, maintain a clean home environment and assist with daily living functions.
- I/we will follow the transplant center treatment plan and any additional requirements set by the transplant center.

By signing below, I indicate that I have reviewed these potential responsibilities and feel comfortable being listed as a caregiver. *If I am unable to fulfill any necessary support throughout the transplant process, I will communicate with the patient and an alternate caregiver to arrange for coverage in my absence.*

1. Primary Caregiver

_____	_____
Patient Caregiver Name (Printed)	Relationship to Patient
_____	_____
Primary Caregiver Signature	Contact Number (Cell)

2. Secondary Caregiver

_____	_____
Secondary Caregiver Name (Printed)	Relationship to Patient
_____	_____
Secondary Caregiver Signature	Contact Number (Cell)

As additional caregiver(s) for _____, I/we agree to assist the primary and secondary caregivers with the previously listed responsibilities.

3. Additional Caregiver Information:

_____ Caregiver Name (Printed)	_____ Relationship to Patient
_____ Caregiver Signature	_____ Contact Number (Cell)

4. Additional Caregiver Information:

_____ Caregiver Name (Printed)	_____ Relationship to Patient
_____ Caregiver Signature	_____ Contact Number (Cell)

5. Additional Caregiver Information:

_____ Caregiver Name (Printed)	_____ Relationship to Patient
_____ Caregiver Signature	_____ Contact Number (Cell)

6. Additional Caregiver Information:

_____ Caregiver Name (Printed)	_____ Relationship to Patient
_____ Caregiver Signature	_____ Contact Number (Cell)