Holland Bloorview
Kids Rehabilitation Hospital

Holland Bloorview

Kids Rehabilitation Hospital
150 Kilgour Road
Toronto ON Canada M4G 1R8
T 416 425 6220
T 800 363 2440
F 416 425 6591
www.hollandbloorview.ca

A teaching hospital fully affiliated with the
University of Toronto

Respite Services

BEFORE completing our respite application form, please review our criteria to make sure that our services are appropriate for your child.

Overnight Respite	**Day Respite**
• Child must require care from a nurse or physician Child must have: • Significant limitations to mobility (e.g. require wheelchair or mobility device much of the time) ***- and -*** • Dependence on medical equipment or technology (e.g. enterostomy tube, tracheostomy, oxygen, ventilation) ***- and/or –*** Requirement of skilled medical treatments (e.g. multiple medication administration, tube feeds, suctioning)	• Child can have a complex physical disability and/or developmental delays. Priority is given to children who require nursing support • Children with a primary and/or secondary diagnosis of Autism are eligible • Child must be comfortable and be able to be successful in a group environment • Maximum 1:1 support is available for children who require this

If your child meets these guidelines, please complete the application form and return it by mail, fax or in person to:

Holland Bloorview Kids Rehabilitation Hospital
Attention: Respite Services
150 Kilgour Rd. Toronto, ON M4G 1R8
Fax: 416-422-7036

Questions? Please contact:
Robyn Sanford
Program Lead Respite Services
(416) 425-6220 ext. 6406
rsanford@hollandbloorview.ca

REF=INPT

Holland Bloorview
Kids Rehabilitation Hospital

RESPITE REQUEST APPLICATION FORM: OVERNIGHT/DAY

Please complete all sections of this form to ensure prompt processing within the requested period.
NOTE: This information will be shared with Holland Bloorview staff as required

Overnight Respite ☐	Day Respite ☐	Both ☐
For Office use only **Date received**:_____ (DD/MM/YYYY)	**This form to be completed each calendar year and updated for changes of information by families.**	Date last updated: _____

Section A – General Applicant Information

To be completed in pen by a family member or health care professional. Please print legibly.

CLIENT DATA:

Client Name:

_____
Surname *First Name* *Middle Initial*

Date of Birth:_____ ☐ Male ☐ Female ☐ Other _____
Day / Month / Year

Pronouns: _____

Is an interpreter required? ☐ Yes ☐ No what Language: _____

Client Address:_____ City:_____

Province:_____ Postal Code:_____

Tel.: _____

Health Card Number:_____ Version Code: _____

Client lives with: ☐ Both parents ☐ Father ☐ Mother ☐ Guardians ☐ Independent ☐ Group Home ☐ Other

PARENT(S) OR GUARDIAN(S):

(1) Parent/Guardian:_____

Address:_____

Email:_____

Tel. (home):_____ Tel. (work):_____ Tel.(cell): _____

(2) Parent/Guardian:_____

Address:_____

Email:_____

Tel. (home):_____ Tel. (work):_____ Tel.(cell): _____

PRIMARY CARE PHYSICIAN:

Name: _____

Address:_____

Tel.: _____ Fax: _____

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Client Name: _____
Surname *First Name* *Middle Initial*

Section B – Client History

Primary Diagnosis:

Secondary Diagnoses:

Please list any allergies:

Treatment for allergies, e.g.; EpiPen, Medication (dosage, route etc.):

Overnight hospital admissions within the last 6 months
☐ Yes ☐ No

If yes, please state reason:

Last time hospitalized:

Immunization up to date: ☐ Yes ☐ No	Had Chicken Pox: ☐Yes ☐No Vaccinated against varicella? ☐ 1 shots ☐ 2 shots
Overnight Respite Requested: ☐ Yes ☐ No	Day Respite requested Check one or both: ☐ Sundays ☐ March Break

In case of Emergency

Emergency Contact's Name:_____

Relationship: _____

Address:_____

Email:_____

Tel. (home):_____Tel. (work):_____Tel. (cell):_____

Custody/Access:

Are there any custody/access restrictions in place? If so, please provide specific details:

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Surname *First Name* *Middle Initial*

Section C- Medical Information: Seizures, Medication

Does your child experience seizures: ☐ Yes ☐ No
If yes, please fill out section below:
Does your child have a Vagal Nerve Stimulator (VNS)? ☐ Yes ☐ No

SEIZURE TYPE, FREQUENCY, TRIGGERS, PATTERN TREATMENT **Description, please include any known triggers:**	DATE OF LAST SEIZURE Day/Month/Year:

Medication

Please include all medications (including over the counter), Please print.

Scheduled Medications

Medication Name	Strength	How Much	How often	Route	Instructions/Reason for Taking
Example: My Drug	*20mg*	*2 tabs*	*8:00am*	*By mouth*	*High Blood Pressure*

As Needed/Unscheduled Medications

Medication Name	Strength	How much	How Often	Route	Special Instructions/ Reasons for taking
Example: My Drug	*100mg*	*2 tabs*	*Every 6 Hours*	*G-Tube*	*For pain or fever*

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Section D- Behaviour/Coping Patterns

☐ Co-operative	
☐ Agitated:	Nighttime (inpatient) Daytime
☐ Aggressive	Verbally ☐ Physically ☐ To self ☐ To others ☐
☐ Exit Seeking	
☐ Triggers	Noise ☐ Light ☐ Frustration ☐ Other: ☐
☐ Wanders	
☐ Withdrawn	

Section E – Communication/Hearing/Vision

(a) Does your child wear hearing aids? ☐ Yes ☐ No

(b) Does your child have speech difficulties? ☐ Yes ☐ No

IF YES to (a) or (b) above, how do they communicate?:

☐ Verbal ☐ Symbol or picture board ☐ Sign language

☐ Other (specify):

☐ able to state needs ☐ communicates with difficulty ☐ unable to communicate ☐ communication devices utilized

Describe:

Vision: ☐ Adequate ☐ Impaired ☐ Blind ☐ Glasses

Describe:

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Surname *First Name* *Middle Initial*

Section F – Mobility Devices

Does your child: ☐ Walk independently ☐ Walk with assistance

Does your child use an assistive device: ☐ Yes ☐ No

IF YES, which of the following do they use:

☐ Cane ☐ Crutches ☐ Walker ☐ Orthotics ☐ Manual Wheelchair ☐ Electric Wheelchair

☐ Stroller: type: _____ ☐ Other: _____

IF THEY USE A WHEELCHAIR, are they able to walk to some extent with assistance?: ☐ Yes ☐ No

Do you consider your child to be at a higher risk for falling?: ☐ Yes ☐ No
(e.g. has fallen in the last three (3) months as a result of diagnosis – poor balance, dizziness, etc.)

For safety reasons, if your child's equipment requires repair during their respite stay, you will be notified and asked to provide alternate equipment or to contact your child's equipment vendor to make a repair. Holland Bloorview staff are not permitted to use unsafe equipment. If replacement equipment is not provided and/or repair is not authorized, this may limit your child's engagement in programs and activities.

Section G- Activities of Daily Living and Personal Care Requirements

Please indicate the level of assistance that your child requires for each of the activities below.
Accuracy in filling out this section is essential to the planning of his/her care.

Task	Total Assistance	Some Assistance	No Assistance	Comments
Eating	☐	☐	☐	
Washing hands	☐	☐	☐	
Dressing	☐	☐	☐	
Mobility	☐	☐	☐	
Showering (inpatient only)	☐	☐	☐	
Toileting	☐	☐	☐	
Transferring On and Off the toilet	☐	☐	☐	
In and out of a wheelchair	☐	☐	☐	

IF YOUR CHILD NEEDS ASSISTANCE WITH TRANSFERRING, please indicate your preferred method:

☐ Hoyer ☐ 2-person transfer ☐ 1-person transfer
Independent

☐ Sliding board transfer

☐ Sling Used (if checked- please bring to respite visit)

Weight in:

Pounds :_____lbs

Kilograms:____kg

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Surname *First Name* *Middle Initial*

Diet/Eating

☐ Regular texture ☐ Special: _____	☐ G-Tube ☐ NG Tube ☐ GJ Tube Tube size: _____ Type and amount of feeding/formula: _____	☐ Difficulty Chewing ☐ Difficulty Swallowing ☐ Bottle fed ☐ Total Parenteral Nutrition (TPN)	Other *(cultural/religious diet implications):*

Elimination

Bowel	Bladder	Requires	Uses
☐ Full control ☐ Occasionally incontinent ☐ Incontinent ☐ Colostomy Bag ☐ Toilet Training	☐ Full control ☐ Occasionally Incontinent ☐ Incontinent ☐ Catheter routine Type/size:_____ Times: _____ ☐ Drainage Condom _____	☐ Diapers/briefs: Size:_____ Type:_____ ☐ Other: _____	☐ Toilet ☐ Commode Chair ☐ Change Table

Section H- Special Needs

Overnight Respite	Day Respite
☐ Ventilator: ☐ 24 hours ☐ Nighttime only ☐ Oxygen Suctioning: ☐ tip ☐ deep ☐ Tracheostomy ☐ PICC line (Peripherally Inserted Central Catheter) ☐ Central Venous Line: ☐ Internal ☐ External ☐ Peripheral IV ☐ TPN ☐ Dialysis ☐ Monitor ☐ Other:	☐ Suctioning: ☐ Tip ☐ Oxygen ☐ Tracheostomy ☐ Other:
Please describe support needed	*Please describe support needed:*

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Client Name: _____
Surname *First Name* *Middle Initial*

Skin condition: Overnight Respite Only

☐ Normal ☐ Wound/Incision(s) ☐ Burn ☐ Stoma Care ☐ Other:

Describe:

Section I – Safety/Sleep

Overnight Respite Only		**Overnight and Day Respite**
☐ Type of bed: _____ ☐ Bed rails ☐ Rail padding ☐ Dome over bed ☐ Climbs out of bed	Sleep: ☐ Sleeps most of night ☐ Awakens frequently Night care routines: ☐ Daytime naps Comments:	☐ Physical restraints *e.g: elbow splints, mitts* Please describe: ☐ Anti-tip bars on wheelchair ☐ Helmet ☐ Other:

Section J- Cancellation Policy

If your cancellation is due to child's illness, you will be reimbursed fully.
Outpatient cancellations may be subject to a processing fee.

Section K - Verification and Signature

I verify that the information that has been given in this application is complete and accurate to the best of my knowledge. I provide consent for the assigned nurse and staff, to administer medication and perform any other procedures or treatment, as directed above, to my child during their respite stay. I will provide up-to- date information regarding treatment or contact information as needed.

Signature: _____	Date: _____ Day/Month/Year

Please return this form by mail, fax or in person:

Mail: Holland Bloorview Kids Rehabilitation Hospital
Attention: Respite Services
150 Kilgour Rd.
Toronto, ON
M4G 1R8

Fax: 416-422-7036

Registration Voice Mail: 416-753-6066

For inquiries:

Overnight respite: Robyn Sanford 416-425-6220 x6406
Day respite: Program Administrator 416-425-6220 x 3317

Please note that submitting an application does not guarantee acceptance.