Holland Bloorview
Kids Rehabilitation Hospital

Respite Services: 150 Kilgour Rd. Toronto, ON M4G 1R8
Tel: (416) 753-6022 Fax: (416) 422-7036

OVERNIGHT RESPITE – FAMILY APPLICATION

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.

Application Checklist

Complete the following steps to submit your Overnight Respite application. Once submitted, we will be in touch to confirm your acceptance at which point you may request dates.

- Step 1 – Complete the **Medical Referral Form** (must be signed by a physician or nurse practitioner). This form can be found at https://hollandbloorview.ca/services/programs-services/respite
- ✓ Step 2 – Complete the **Family Application Form** (this form). *Note: this can be submitted with the Medical Referral Form in Step 1.*
- Step 3 – Submit supporting documentation (this is often provided by the medical referrer) such as:
  - Medication list
  - Immunization record (if available)
  - Complex care plan
  - Behaviour/Safety plan

Introduction & Eligibility

This application form is Part 2 of the application process. Part 1 of the application is the medical referral form. Please visit our website (hollandbloorview.ca/services/programs-services/respite) for details on the process and a copy of the medical referral form.

BEFORE completing the Overnight Respite application form, please review our eligibility criteria below, to make sure our services are appropriate for your child.

Overnight Respite Eligibility

Child must meet the following service criteria:

- Be under 19 years old
- Benefit from care provided by a nurse or a physician
- Have significant challenges with mobility (i.e., require wheelchair or mobility device much of the time)

- and –

- Require skilled medical treatments (i.e., multiple medication administration, tube feeds, suctioning, etc.)

- and/or –

- Be dependent on medical equipment or technology (i.e., enterostomy tube, tracheostomy, oxygen, ventilation, etc.)

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

Holland Bloorview Kids Rehabilitation Hospital
Attention: Respite Services
150 Kilgour Road, Toronto, ON M4G 1R8
Fax: (416)-422-7036 Email: overnightrespite@hollandbloorview.ca

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Personal Information:

Client Name: _____

Date of Birth: _____ Gender: ☐ Female ☐ Male ☐ Other

Preferred Pronouns: ☐He/Him/His ☐She/Her/Hers ☐ They/Them/Theirs

Weight in Kg: _____

Clients Primary Address: _____

City: _____ Postal Code: _____

OHIP: ☐ No ☐ Yes, OHIP#: _____ Version Code: _____

Decision-making and Parenting Arrangements

Name of Legal Guardian(s): _____

Relationship to client: _____

Client lives with: ☐ Parent(s)/Legal Guardian(s) ☐ Separated/Split Arrangement

☐ Extended Family Caregiver/Kinship Caregiver ☐ Under Care of Child Protection Agency/Foster Family

☐ Independent ☐ Group Home ☐ Other, please specify: _____

Are there any decision-making or parenting time agreements (formerly referred to as custody and access) that the health care team should be aware of? ☐ Yes ☐ No

If Yes, Please Specify: _____

_____

_____

CAS Involvement: ☐ Yes ☐ No

If Yes, CAS case worker name and contact information: _____

_____

_____

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Emergency Contact During Respite Stay (Must be a family Member)

Name: _____

Relationship to Client: _____

Phone: _____ Email: _____

Medical Information

Primary Diagnosis:

Secondary Diagnoses:

Emergency Code Status

In the event of an acute medical emergency:

- ☐ Attempt full resuscitation
- ☐ Attempt modified resuscitation (letter or medical directive to be included)
- ☐ Do not attempt resuscitation (letter or medical directive to be included)

Pain Management

Is there a history of pain: ☐ No ☐ Yes If yes, describe the type of pain and triggers:

Medications to treat:

Other therapies to treat: ☐ Heat/Cold ☐ Massage ☐ Guided Imagery ☐ Distraction

☐ Other (please specify): _____

How does your child communicate pain:

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Functional Abilities

Please specify how your child gets around (mobilize) – select all that apply:

☐ Walks Independently ☐ Manual support from a caregiver (handheld, gait belt, etc.) ☐ Cane

☐ Crutches ☐ Walker ☐ Orthotics ☐ Manual Wheelchair ☐ Power Wheelchair ☐ Stroller

☐ Other (please specify): _____

Risk of falls: ☐ No ☐ Yes

Mobility Equipment/Supports (select all that apply):

☐ None ☐ Helmet ☐ Stander ☐ Neck Collar ☐ Back Brace

☐ AFOs/SMOs ☐ Elbow Splint ☐ Wrist Splint ☐ Mitts ☐ Anti Tip Bars

☐ Other (please specify): _____

Activities of Daily Living (ADL)

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	☐	☐	☐	
Showering	☐	☐	☐	
Toileting	☐	☐	☐	

Transferring Method: ☐ No Assistance Required ☐ Ceiling Lift (e.g. Hoyer) ☐ Sliding Board

☐ 2-Person Manual Transfer ☐ 1-person Manual Transfer ☐ Pivot Transfer Device (e.g. Mo-Lift)

Comments:

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Communication/Hearing/Vision

How does your child communicate? (select all that apply):

- ☐ Verbally
- ☐ Symbol or Picture Board
- ☐ Sign Language
- ☐ Gestures
- ☐ Communication Device
- ☐ other (please specify): _____

Please select the option that best describes your child's vision:

- ☐ Typical Vision without Glasses
- ☐ Typical Vision with Glasses (corrected)
- ☐ Visually Impaired
- ☐ Blind
- ☐ Other (please specify): _____

Please select the option that best describes your child's hearing:

- ☐ Typical Hearing without Hearing Aids
- ☐ Typical Hearing with Hearing Aids (specify type): _____
- ☐ Hearing Impaired
- ☐ Deaf
- ☐ Other (please specify): _____

Sleep Routines

Your child:

Sleeps Through the Night	☐ Yes	☐ No	☐ Sometimes Wakes
Frequently	☐ Yes	☐ No	☐ Sometimes
Daytime Naps	☐ Yes	☐ No	☐ Sometimes Climbs
Out of Bed	☐ Yes	☐ No	☐ Sometimes

Additional Information:

Type of Bed:

☐ Regular ☐ Bed Rails ☐ Rail Padding ☐ Medical Safety Bed/Crib

☐ Other (please specify): _____

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Behavioural Patterns

Please select the option that best describes your child's behaviour:

- ☐ Co-operative/No Behavioural Concerns
- ☐ Agitated Behaviour
  - Triggers: _____
  - Deescalation Strategies: _____
- ☐ Verbally Aggressive
  - Triggers: _____
  - Deescalation Strategies: _____
- ☐ Physically Aggressive
  - If yes, aggressive to: ☐ Themselves ☐ Others
  - Triggers: _____
  - Deescalation Strategies: _____

Is your child prone to wandering: ☐ Yes ☐ No

Is your child prone to exit seeking: ☐ Yes ☐ No

Please include behavioural safety plan if applicable.

Additional Information

Additional Information We Should Know About Your Child

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Respite Goals

1. What are your goals from respite?

2. What do you hope your child gains from respite?

3. What do you hope respite provides for your family?

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Supporting Documentation

Please include additional supporting documentation such as:

- Medication List
- Immunization Record (if available)
- Complex Care Plan
- Behaviour/Safety Plan

This documentation is optional and may be received from the medical referrer.

Consent

By submitting this application, you authorize Holland Bloorview Kids Rehabilitation Hospital to disclose your personal health information to your family physician, or other physician identified by you, for the purposes of obtaining a referral for respite services. A separate physician referral is required to complete your application for this service. In addition, you acknowledge that if you revoke this authorization, this will not affect any disclosures that were made prior to processing the revocation request.

Name: _____	Date: _____ Day/Month/Year
Signature: _____	