Holland Bloorview
Kids Rehabilitation Hospital

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

OVERNIGHT RESPITE REFERRAL FORM

Please Note: *The timeline for review is 72 hours. If this is an urgent request, please contact the Clinical Lead, Access & Flow, (416) 425-6220 ext.3197. Otherwise, you will be contacted. If assistance is required in completing this form, please contact the Clinical Lead, Access & Flow Holland Bloorview Kids Rehabilitation Hospital cannot initiate and / or maintain Peripheral Intravenous therapies.*

This referral form must be signed by a medical professional (physician or nurse practitioner).
This is Part 1 of a 2-part application process. Part 2 is the Family Application which can be found at: https://hollandbloorview.ca/services/programs-services/respite.

Referral Urgency *(Note: routine referrals are reviewed in 7 business days. Urgent requests will be reviewed in 72 hours)*

☐ Routine ☐ Urgent

Referral Source

☐ SickKids ☐ McMaster Children's ☐ London Children's ☐ CHEO ☐ Physician/NP

☐ Other:_____ Key Team Contact:_____

Team Contact/Key Worker Contact#:_____ Email: _____

Referring Provider Contact#:_____ OHIP Billing Number:_____

MRP:_____ Contact#:_____

Client Information

Client Name:_____

Chosen Name:_____ Pronoun: ☐He/Him/His ☐She/Her/Hers ☐ They/Them/Theirs

Clients Primary Address:_____

City:_____ Postal Code:_____

Date of Birth: _____ ☐ Female ☐ Male ☐ Other Weight in Kg:_____

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

If No, Please Explain: _____

Caregiver #1 Name: _____ Relationship to Client: _____

Phone Number: _____ Email: _____

Address: _____

Language Spoken by Caregiver: _____ Interpreter Required: ☐ Yes ☐ No

If Yes, Specify Language: _____

Caregiver #2 (if applicable) Name: _____ Relationship to Client: _____

Phone Number: _____ Email: _____

Address: _____

Language Spoken by Caregiver: _____ Interpreter Required: ☐ Yes ☐ No

If Yes, Specify Language: _____

Client Lives With: ☐ Parent(s)/Legal Guardian(s) ☐ Separated/Split Arrangement

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

☐ Independent ☐ Group Home ☐ Other (please specify): _____

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Decision-making and Parenting Arrangements

Name of Legal Guardian(s): _____

Relationship to child (if different from caregiver): _____

Are there any decision making or parenting time arrangements (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: _____

Care Team Information

Please provide contact information for the Primary Care Provider if different from referring care provider (e.g. pediatrician, family physician, primary care NP)

Provider Name: _____

Clinic Name: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Phone Number: _____ Fax Number: _____

Medical History

Primary Diagnosis: _____

Secondary Diagnosis(es): _____

Weight in Kg: _____ Overnight Hospital Admission within the last 12 months? ☐ No ☐ Yes

If yes, please state date and reason for admission: _____

_____

If no, please state date of last admission: _____

Relevant Medical History: _____

_____

_____

_____

Immunizations Up to Date: ☐ No ☐ Yes (please include immunization record if available)

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)

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Medical History

Isolation/Infection Control Required: ☐ No ☐ Yes

If Yes, Please Specify: _____

_____

Client Medication Profile

Allergies	
Reaction to allergies?	
Epi-pen required?	

Medication name, strength & dosage form	Dose	Route	Frequency	Comments
Complementary and alternative medicines				
Substance use/medicinal marijuana				
Hazardous/cytotoxic medications that requires special handling				

Key Contact for Medication-Related Issues: _____

Contact #: _____

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Nutrition/Diet

Oral Feeding: ☐ Yes ☐ No ☐ Tastes Only ☐ Unsure
If yes, indicate if there is a specialized diet or any known food or liquid modifications (e.g. puree only, thickening recommendations, etc.):

Feeding Instructions:

Enteral (tube) Feeding: ☐ No ☐ Yes Date of Insertion (if within the last year): _____

If yes, select all that apply: ☐ NG-tube ☐ NJ-tube ☐ G-tube ☐ GJ-tube ☐ Combo G/GJ tube

☐ Other, please describe: _____

Feeding schedule and type (e.g. formula type/recipe, rate, feed times, flushes, additional instructions):

Total Parenteral Nutrition (TPN) ☐ Yes ☐ No If yes, please specify TPN type/formulation/schedule:

Special Diet: ☐ No ☐ Yes

If yes, select type: ☐ EBM/Formula ☐ Vegan ☐ Vegetarian ☐ Kosher ☐ Halal ☐ Keto ☐ Blended Tube Feed

Other relevant feeding information not included above:

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Neurology Supports: ☐ NO ☐ Yes ☐ Unsure

Seizures: ☐ No ☐ Yes

Type: _____

Frequency: _____

Description of Seizure: _____

Routine Management (medication, diet, VNS, etc.):

Emergency Management (medication, VNS, etc.):

Tone/Dystonia Management: ☐ No ☐ Yes

If yes, specify routine management and include medication details and dystonia escalation plan:

Deep Brain Stimulator: ☐ Yes ☐ No Baclofen Pump: ☐ Yes ☐ No VP Shunt: ☐ Yes ☐ No

Other neurology conditions or supports:

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Respiratory Supports: ☐ Yes ☐ No ☐ Unsure

Asthma: ☐ Yes ☐ No

If yes, management (e.g. oral medications, inhaled medications) _____

_____

Pneumonia or frequent respiratory infections: ☐ Yes ☐ No

History of aspiration: ☐ Yes ☐ No

If yes, Aspiration on (select all that apply): ☐ Secretions ☐ Reflux/Vomit ☐ Oral (food/liquid)

If yes, please include results of last Video Fluoroscopic Swallowing Study (VFSS) or clinical feeding assessment if available.

Oxygen: ☐ Yes ☐ No

If yes, specify flow, interface and schedule of use:

Suctioning: ☐ Yes ☐ No

If yes, please select type: ☐ Oral ☐ Nasal ☐ Tracheostomy ☐ Deep

Noninvasive Ventilation (e.g. CPA, BiPAP, APAP): ☐ Yes ☐ No

If yes, please select type: ☐ CPAP ☐ BiPAP ☐ APAP ☐ Other (please specify): _____

If yes, specify settings if known/available: _____

_____

If yes, select interface/mask type: : ☐ Nasal Mask ☐ Full Face Mask

If yes, can child remove their own mask: ☐ Yes ☐ No

Tracheostomy: ☐ Yes ☐ No If yes: Type_____Size:_____

Date of Insertion (if within the last year): _____

If yes, specify humidification: ☐ Cool Humidity ☐ Heated Humidity ☐ None

If yes, using HME and/or speaking valve: ☐ Yes ☐ No

If using HME and/or speaking valve, add schedule of use:

Invasive Ventilation (i.e. through tracheostomy): ☐ Yes ☐ No

If yes, please specify use: ☐ during sleep (overnight, naps, etc.) ☐ Full time (24/7)

If yes, include settings if known/available:

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Heated High Flow (HHF) Therapy (e.g., airvo): ☐ No ☐ Yes

If yes, please provide instructions if known/available (e.g., temp, flow rate, etc.):

In/exsufflator (cough assist): ☐ No ☐ Yes

If yes, add settings if known/available: _____

Chest physio: ☐ Yes ☐ No

If yes, provide instructions:

Other respiratory conditions or supports:

Specialized Bowel and Bladder Routine: ☐ Yes ☐ No ☐ Unsure

If yes, select all that apply: ☐ MACE ☐ Cone Enema ☐ Colostomy ☐ Persiteen

☐ Clean intermittent Catheter ☐ Indwelling Catheter ☐ Mitrofanoff Catheter ☐ Other: _____

Skin Condition(s): ☐ Yes ☐ No ☐ Unsure

If yes, select all that apply: ☐ Wound/Incision ☐ Burn ☐ Stoma Care Specialized Dressing

☐ Rash ☐ Other (please specify): _____

If yes, please specify and provide specific care routine(s):

Access

Does the client have a CVC/PICC Line/Port: ☐ Yes ☐ No

If yes, please specify line type and details of care:

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Does the Client Have Psychosocial or Behavioural Issues: ☐ Yes ☐ No ☐ Unsure

Are there client related safety risks (e.g., falls, wandering, aggression, substance misuse, other):

☐ Yes ☐ No ☐ Unsure

If yes, provide details and safety strategies (e.g. behavioural plan):

Provide any relevant family related psychosocial information (e.g., CAS Involvement, living in a shelter, family emergency, etc.):

Restraints Needed: ☐ Yes ☐ No ☐ Unsure

If yes, select all that apply: ☐ Vail Bed ☐ Elbow Restraints ☐ Gloves ☐ Houdini Seatbelt

☐ Other (please specify): _____

Other Relevant Information (e.g., pain management, other technology, other relevant supports and medical information):

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Supporting Documentation

Please attach the following if available:

- Medication list
- Specialized medication plan *(e.g., diabetes management, dystonia escalation protocol, seizure rescue plan, steroid stress dosing, etc.)*
- Immunization Record (if available)
- Cough Assist Order
- Ventilation Orders
- CPAP/BiPAP Orders
- Specialty Feed Orders (e.g., ketogenic diet)
- Complex Care Plan
- Behaviour/Safety Plan
- Letter of Medical Directive Regarding Code Status
- Any Other Relevant Documentation