

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
<ul style="list-style-type: none"> • Child must require care from a nurse or physician <p>Child must have:</p> <ul style="list-style-type: none"> • Significant limitations to mobility (e.g. require wheelchair or mobility device much of the time) <li style="text-align: center;">- and - • Dependence on medical equipment or technology (e.g. enterostomy tube, tracheostomy, oxygen, ventilation) <li style="text-align: center;">- and/or - • Requirement of skilled medical treatments (e.g. multiple medication administration, tube feeds, suctioning) 	<ul style="list-style-type: none"> • Must have a complex physical disability and developmental delays. Priority is given to children who require nursing support • Children with a primary diagnosis of Autism are not eligible. Children with a secondary diagnosis of Autism may be 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

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 <input type="checkbox"/>	Day Respite <input type="checkbox"/>	Both <input type="checkbox"/>
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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: _____ (DD/MM/YYYY)
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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
 Day / Month / Year

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):

Mother/ Guardian:

Address: _____

Email: _____

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

Father/

Guardian:

Address: _____

Email: _____

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

PRIMARY CARE PHYSICIAN:

Name: _____

Address: _____

Tel.: _____

Fax: _____

Holland Bloorview

Kids Rehabilitation Hospital

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? <input type="checkbox"/> 1 shot <input type="checkbox"/> 2 shots
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Overnight Respite requested	Day Respite requested Circle one or both: Sundays March Break
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In case of Emergency

Emergency Contact's Name: _____
Relationship: _____
Address: _____
Email: _____
Tel. (home): _____ Tel. (work): _____ Tel. (cell): _____

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 Description, please include any known triggers	TREATMENT	DATE OF LAST SEIZURE Day/Month/Year

Holland Bloorview

Kids Rehabilitation Hospital

Client Name: _____
Surname First Name Middle Initial

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/Reason for taking
Example: My Drug	100mg	2 tabs	Every 6 hours	G-Tube	For pain or fever.

Please note these medications will be reviewed prior to admission, and on the day of admission. At Holland Bloorview we are committed to medication safety, all medications must be brought in their original containers.

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					
<input type="checkbox"/> Withdrawn					

Client Name: _____
Surname
FirstName
MiddleInitial

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: _____

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Washing hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Client Name: _____				
<i>Surname</i>		<i>First Name</i>		<i>Middle Initial</i>
Task	Total Assistance	Some Assistance	No Assistance	Comments
Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Showering (inpatient only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Transferring: On and off the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
In and out of a wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
IF YOUR CHILD NEEDS ASSISTANCE WITH TRANSFERRING, please indicate your preferred method: <input type="checkbox"/> Hoyer <input type="checkbox"/> 2-person transfer <input type="checkbox"/> 1-person transfer <input type="checkbox"/> Independent <input type="checkbox"/> Sliding board transfer <input type="checkbox"/> Sling Used (if checked- please bring to respite visit)			Weight in: Pounds : _____ lbs Kilograms: _____ kg	
Diet/Eating				
<input type="checkbox"/> Regular texture <input type="checkbox"/> Special: _____	<input type="checkbox"/> G-Tube <input type="checkbox"/> NG Tube <input type="checkbox"/> GJ Tube Tube size: Type and amount of feeding/formula:	<input type="checkbox"/> Difficulty chewing <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Bottle fed <input type="checkbox"/> Total Parenteral Nutrition (TPN)	Other (cultural/religious diet implications):	
Elimination				
Bowel	Bladder	Requires	Uses	
<input type="checkbox"/> Full control <input type="checkbox"/> Occasionally incontinent <input type="checkbox"/> Incontinent <input type="checkbox"/> Colostomy bag <input type="checkbox"/> Toilet Training	<input type="checkbox"/> Full control <input type="checkbox"/> Occasionally incontinent <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheter routine Type/size: _____ Times: _____ <input type="checkbox"/> Drainage condom _____	<input type="checkbox"/> Diapers/briefs: size: _____ Type: _____ <input type="checkbox"/> Other:	<input type="checkbox"/> Toilet <input type="checkbox"/> Commode chair <input type="checkbox"/> Change Table	

Client Name: _____
Surname
First Name
Middle Initial

Section H - Special Needs

Overnight Respite	Day Respite
<input type="checkbox"/> Ventilator: <input type="checkbox"/> 24 hours <input type="checkbox"/> Nighttime only <input type="checkbox"/> Oxygen <input type="checkbox"/> Suctioning: <input type="checkbox"/> tip <input type="checkbox"/> deep <input type="checkbox"/> Tracheostomy <input type="checkbox"/> PICC line (Peripherally Inserted Central Catheter) <input type="checkbox"/> Central Venous Line: <input type="checkbox"/> Internal <input type="checkbox"/> External <input type="checkbox"/> Peripheral IV <input type="checkbox"/> TPN <input type="checkbox"/> Dialysis <input type="checkbox"/> Monitor <input type="checkbox"/> Other:	<input type="checkbox"/> Suctioning: <input type="checkbox"/> tip <input type="checkbox"/> Oxygen <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Other:
<i>Please describe support needed:</i>	<i>Please describe support needed:</i>

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	
<input type="checkbox"/> Type of bed: _____ <input type="checkbox"/> Bed rails <input type="checkbox"/> Rail padding <input type="checkbox"/> Dome over bed <input type="checkbox"/> Climbs out of bed	Sleep: <input type="checkbox"/> Sleeps most of night <input type="checkbox"/> Awakens frequently Night care routines: <input type="checkbox"/> Daytime naps Comments:	<input type="checkbox"/> Physical restraints e.g: elbow splints, mitts Please describe: <input type="checkbox"/> Anti-tip bars on wheelchair <input type="checkbox"/> Helmet <input type="checkbox"/> Other:

Client Name: _____
Surname First Name Middle Initial**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: Avni Shah 416-425-6220 x 3317

Please note that submitting an application does not guarantee acceptance.