Respite Services

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

<table>
<thead>
<tr>
<th>Overnight Respite</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Child must require care from a nurse or physician</td>
</tr>
<tr>
<td>Child must have:</td>
</tr>
<tr>
<td>• Significant limitations to mobility (e.g. require wheelchair or mobility device</td>
</tr>
<tr>
<td>much of the time)</td>
</tr>
<tr>
<td>- and -</td>
</tr>
<tr>
<td>• Dependence on medical equipment or technology (e.g. enterostomy tube,</td>
</tr>
<tr>
<td>tracheostomy, oxygen, ventilation)</td>
</tr>
<tr>
<td>- and/or -</td>
</tr>
<tr>
<td>• Requirement of skilled medical treatments (e.g. multiple medication</td>
</tr>
<tr>
<td>administration, tube feeds, suctioning)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Day Respite</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Must have a complex physical disability and developmental delays. Priority is</td>
</tr>
<tr>
<td>given to children who require nursing support</td>
</tr>
<tr>
<td>• Children with a primary diagnosis of Autism are not eligible. Children with a</td>
</tr>
<tr>
<td>secondary diagnosis of Autism may be eligible</td>
</tr>
<tr>
<td>• Child must be comfortable and be able to be successful in a group environment</td>
</tr>
<tr>
<td>• Maximum 1:1 support is available for children who require this</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Overnight Respite</th>
<th>Day Respite</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Office use only</td>
<td>This form to be completed each calendar year and updated for changes of information by families.</td>
<td>Date last updated:</td>
</tr>
<tr>
<td>Date received: (DD/MM/YYYY)</td>
<td>Date last updated: (DD/MM/YYYY)</td>
<td></td>
</tr>
</tbody>
</table>

**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:

<table>
<thead>
<tr>
<th>Surname</th>
<th>First Name</th>
<th>Middle Initial</th>
</tr>
</thead>
</table>

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: ________________________
**Section B – Client History**

**Primary Diagnosis:**

**Secondary Diagnoses:**

**Please list any allergies:**

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

<table>
<thead>
<tr>
<th>Overnight hospital admissions within the last 6 months</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>if yes, please state reason:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>last time hospitalized:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immunization up to date: Yes</th>
<th>No</th>
<th>Had Chicken Pox: Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccinated against varicella?</td>
<td>1 shot</td>
<td>2 shots</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overnight Respite requested</th>
<th>Day Respite requested</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Circle one or both:</td>
</tr>
<tr>
<td></td>
<td>Sundays</td>
</tr>
<tr>
<td></td>
<td>March Break</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>SEIZURE TYPE, FREQUENCY, TRIGGERS, PATTERN</th>
<th>TREATMENT</th>
<th>DATE OF LAST SEIZURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description, please include any known triggers</td>
<td></td>
<td>Day/Month/Year</td>
</tr>
</tbody>
</table>

*REF=INPT*
Medication

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

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Strength</th>
<th>How Much</th>
<th>How often</th>
<th>Route</th>
<th>Instructions/Reason for taking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: My Drug</td>
<td>20mg</td>
<td>2 tabs</td>
<td>8:00am</td>
<td>By mouth</td>
<td>High Blood pressure</td>
</tr>
</tbody>
</table>

As Needed/Unscheduled Medications

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Strength</th>
<th>How much</th>
<th>How often</th>
<th>Route</th>
<th>Special instructions/Reason for taking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: My Drug</td>
<td>100mg</td>
<td>2 tabs</td>
<td>Every 6 hours</td>
<td>G-Tube</td>
<td>For pain or fever.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Agitated:</th>
<th>Nighttime (inpatient)</th>
<th>Daytime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggressive</td>
<td>Verbally</td>
<td>Physically</td>
</tr>
</tbody>
</table>

Exit-Seeking

<table>
<thead>
<tr>
<th>Triggers:</th>
<th>Noise</th>
<th>Light</th>
<th>Frustration</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wanders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ Withdrawn

*REF=INPT*
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: __________________  ☐ 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.

<table>
<thead>
<tr>
<th>Task</th>
<th>Total Assistance</th>
<th>Some Assistance</th>
<th>No Assistance</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washing hands</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Task

<table>
<thead>
<tr>
<th>Task</th>
<th>Total Assistance</th>
<th>Some Assistance</th>
<th>No Assistance</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Showering (inpatient only)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transferring: On and off the toilet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In and out of a wheelchair</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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

## 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

- [ ] Full control
- [ ] Occasionally incontinent
- [ ] Incontinent
- [ ] Colostomy bag
- [ ] Toilet Training

### Bladder

- [ ] Full control
- [ ] Occasionally incontinent
- [ ] Incontinent
- [ ] Catheter routine
  - [ ] Type/size: _______
  - [ ] Times: _______
- [ ] Drainage condom

### Requires

- [ ] Diapers/briefs:
  - [ ] size: _______
  - [ ] Type: _______

### Uses

- [ ] Toilet
- [ ] Commode chair
- [ ] Change Table
## Section H - Special Needs

### Overnight 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:

### Day Respite

- Suctioning:  
  - Tip
- Oxygen
- Tracheostomy
- Other:

Please describe support needed:

<table>
<thead>
<tr>
<th>Skin Condition: Overnight Respite Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
</tr>
</tbody>
</table>

Describe:

### Section I – Safety/Sleep

#### Overnight Respite Only

- 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:

#### Overnight and Day Respite

- 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.

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date: Day/Month/Year:</th>
</tr>
</thead>
</table>

**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.*