Date Referral Received: ______________________

RESPITE INQUIRY AND REFERRAL FORM

Child's Name	Date of Birth	Gender	Health Card Number
Primary Contact #1	**Relation to Child**	**Primary Number**	**Language Spoken**
Address		**Email**	
Primary Contact #2	**Relation to Child**	**Primary Number**	**Language Spoken**
Address		**Email**	
Child Lives with:		**Custody Status**	
Primary Physician		**Office Number**	**Fax Number**

HEALTH PROFILE

Diagnosis:

Allergies:

Seizure Disorder

- ☐ **List type of seizures:**

☐ VP Shunt	☐ Daily Medications	☐ PRN Medications
☐ Ketogenic Diet	☐ Vagus Nerve Stimulation (VNS)	☐ CBD Oil

Respiratory System	Inhalation Therapies:		
☐ Asthma	☐ Oxygen	☐ Suctioning	☐ Sleep Apnea
☐ Aspiration	☐ Mask	☐ Tip	☐ CPAP
☐ Frequent colds	☐ Nasal Prong	☐ Deep	☐ BIPAP
☐ Wheezing	☐ Continuous Flow	☐ Tracheal	☐ APAP
☐ Pneumonia	☐ As needed		
☐ Other:	☐ Inhalers	☐ Ventilator	☐ Tracheotomy
	☐ Daily Need	☐ Overnight	☐ Cough Assist
	☐ PRN	☐ 24/7	☐ Chest Physio

Date Referral Received: ____________________

RESPITE INQUIRY AND REFERRAL FORM

Diabetes	Intravenous Therapy		
☐ Bloor Sugar Check	☐ Central Venous Access Device	☐ Peripheral IV	☐ CADD Pump
☐ Insulin Injection	☐ Central Line	☐ TPN	☐ Other:
☐ Insulin Pump	☐ PICC Line	☐ Dialysis	
	☐ Port Line	☐ Injections	

Enteral Feeding	Medication Administration	Elimination	
☐ G-tube	☐ Oral	☐ Colostomy	☐ Catheterization
☐ GJ-tube	☐ via feeding tube	☐ Urostomy	☐ Continuous
☐ J-tube	☐ Nebulizer	☐ Ileostomy	☐ Intermittent
☐ NG-tube	☐ Puffers	☐ Mitrofanoff	☐ Drainage Condom
	☐ Injections	☐ Mace	

Other medical considerations

☐ Other technology-dependent or life sustaining equipment:

☐ Other:

Mobility Aids

☐ Manual wheelchair	☐ Powerchair	☐ Walker	☐ Stroller
☐ Helmet	☐ Ankle-Foot Orthotics	☐ Hand-Wrist Orthotics	☐ Neck Collar
☐ Back Brace	☐ Stander	☐	☐

Psychosocial/Behaviour Patterns

Given the fragility of the population we serve, a client may not be appropriate for our services if they demonstrate aggressive or self-injurious behaviours which pose a risk to themselves and/or other clients in care, or that which requires significant behavioural support. However, this is reviewed on a case-by-case basis following completion of a Safehaven assessment and in consultation with community resources and support.

☐ Biting ☐ Hitting ☐ Yelling ☐ Spiting ☐ Exit-seeking ☐ Self-Injurious

☐ Other:

Community Supports

Has the client used out-of-home respite before? ☐ Yes ☐ No

Where have you used out-of-home respite?

Name of person completing application: ____________________

Relationship to client: ____________________

Date of completion: ____________________

PLEASE FORWARD FORM TO:

Mail:
Safehaven,1173 Bloor Street West, Toronto, ON M6H 1M9

Fax:
416-535-9782

Email:
respite@safehaven.to

Thank you for taking the time to complete this form.