



# Reference | In-Home Respite Program

Surname \_\_\_\_\_

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Gender M  F  Other  :

Medicare \_\_\_\_\_

### Support System (other than caregiver)

Name of family or significant person \_\_\_\_\_

\_\_\_\_\_

Cell \_\_\_\_\_

Home \_\_\_\_\_

Office \_\_\_\_\_

Reason for request \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Primary diagnosis: (date) \_\_\_\_\_

\_\_\_\_\_

Infectious disease: (specific precautions) \_\_\_\_\_

\_\_\_\_\_

Related diagnosis:/ services received (dates) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Requested by \_\_\_\_\_

Department \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_

Postal Code \_\_\_\_\_

### Caregiver

Name \_\_\_\_\_

Age \_\_\_\_\_ Language \_\_\_\_\_

Number of hours per week \_\_\_\_\_

Cell \_\_\_\_\_

Home \_\_\_\_\_

Office \_\_\_\_\_

Medications \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medical follow-up \_\_\_\_\_

\_\_\_\_\_

Telephone \_\_\_\_\_

Fax \_\_\_\_\_

Pager \_\_\_\_\_

Hospital / Address \_\_\_\_\_

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\_\_\_\_\_

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CLSC / Other Implicated

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Telephone

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Fax

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Pager

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CLSC / Other Implicated

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Telephone

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Fax

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Pager

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**Physical Abilities / Incapacity**

Inability:  Mobility       Behaviour       Incontinence

Communication     Mental Status     Motivation

Identify Hazards     Management of medication

Other relevant issues

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Supplies / equipment

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**Others professionals implicated**

Name

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Profession

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Telephone

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Name

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Profession

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Telephone

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**Situation/ Family Support Issues**

Specifics

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Description of the network support and services  
(neighbours, organizations)

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Other information i.e. references in progress,  
pre-admission in palliative care

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**Consent for reference and transmission information**

Agree     Disagree

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Financial capacity: approximate annual household income

Less than \$25,000     \$25,000 - \$40,000     More than \$40,000

Comments

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Date

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Name

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Signature

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