1047 Wadey Drive Regina, SK S4N 7J6 (306)352-3223

At A Glance

Name: ______________________ **DOB:** _________**Age:** _____ **Date:** _____________
Care Provider/Parent(s): ____
Home: ________________ **Cell:** _________________ **Work:** ____________________
Address: ____ **Postal Code**: __________
Email Address: ____
*** Note: Emergency Contact must be different than the care provider/parent**
Emergency Contact Name #1: ____
Home:________________ **Cell:** _________________ **Work:** _____________________
Emergency Contact Name #2: ____
Home: _________________ **Cell:** ________________ **Work:** ____________________
CLSD/Family Service Worker Name: __________________ **Phone:** ______________
SHSP #: ____________________
Doctor Name: _________________________ **Phone:** ___________________________
In Case of Emergency take to ________________________________ **Hospital**
Allergies: Medication: ____
Food: ____
Other: ____
All over the counter medications must be blister packed
Behavioral Concerns:
To others ___Never ___Rarely ___Sometimes ___Often
To Self ___Never ___Rarely ___Sometimes ___Often
Sexual Acting Out ___Never ___Rarely ___Sometimes ___Often
Other: ___________ ___Never ___Rarely ___Sometimes ___Often
Describe above behaviors: ____
____.
Describe causes and interventions: _______________________________________
____.
Risk of Running Away/Wandering: ___None ___Some ___Often
Day Program/School Attending: ____
Phone Number: ______________________
Dietary Concerns/Special Diet: ____
____.
Feeding: ___Independent ___Partial Assistance ___Total Assistance ___Tube feed
___Regular ___Cut ___Minced ___ Pureed ___Finger Foods
Bowel/Bladder Concerns: ___Independent ___Reminders ___Partial Assistance
___ Requires Bowel Care ___ Attends/Diapers
Bathing: ___Regular Tub ___Jacuzzi ___Mechanical Lift ___Blue Chair
Interests and Activities: ____
____
____.
Travel Arrangements: ___Front Seat ___Back Seat ___Beside Staff ___Anywhere
___ Paratransit/Paratransit # ______________

___________________________ ______________________________________
Date **Signature**

For Office Use Only: Date Received: ____
Seizure Protocol Included: ___ **Yes** ___ **No**

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Medical Report

TO BE COMPLETED BY PHYSICIAN

Name: ______________________________________ Sex: _____________ Age: ______
Examining Physician Name (Please Print): ____________________________________

1. **How long has patient been under your care? _______________________________**
2. **Diagnosis: ____.**
3. **Medications: ___ Yes ___ No, If yes please specify below:**

Name of Medication | **Dosage** | **Frequency (Times)**

____
____
____
____
____
____
____
____

4. **Allergies or drug tolerances? ___ Yes ___ No, If yes please specify below:**

____
____.

5. **Seizures: ___ Yes ___ No, If yes please specify type and frequency:**

____
____.

6. **History of eye, ear, nose, and throat infections? ___ Yes ___ No**
7. **Special diet? ___ Yes ___ No, If yes please specify: ___________________________**

____
____.

8. **Is patient free of all communicable diseases? ___ Yes ___ No, If no please specify:**

____
____.

9. **Are immunizations up to date (i.e. DPT, OPV, and MMR)? ___ Yes ___ No**
10. **Emotional problems? ___ Yes ___ No, If yes please specify: _________________**

____
____.

11. **Special physical problems or needs (i.e. Tube feeding, oxygen therapy, physiotherapy, chronic conditions). Include use of mechanical or physical aid (please specify): ____**

____.

12. **List all behavioral concerns (if more room required please use back of form):**

____
____.

_______________________________ _______________________________
Physicians Signature **Date**

For Office Use Only: Date Received: ____
Seizure Protocol Included: ___ Yes ___ No

Seizure Protocol

Name: ____

Type(s) of Seizure: ____
____
____
____
____.

Typical warning signs of Seizure (in behavior or appearance): _________________
____
____
____
____
____.

Protocol for medications (PRN): (i.e. after _______ minutes of seizure activity give ________; or after ___________ seizures in ___________hours, give _________).
____
____
____
____
____.

Protocol for emergency transportation: (i.e. after _____ minutes of seizure, call 911; ambulance to take to _______________ hospital; or after ___________ seizures in _______ hours call 911, ambulance to take to _____________ hospital).
____
____
____
____
____.

General Notes: ____
____
____
____
____
____.

For Office Use Only: Date Received: ____
Seizure Protocol Included: ___ Yes ___ No

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ADMISSION APPLICATION FORM

Personal Information (Confidential)

Name of Applicant: ____________________________ Date: ________________________

Address: ____

City: _____________________________ Postal Code: __________________________

Date of Birth: _______________ Age: _______ Height: _______ Weight: ________
(day/month/year)

Health Card Number: _______________________ M.S.I. or G.M.S.: _________________

Medical Alert Identification Number (if applicable): ______________________________

Has Applicant used the Respite Home previously: ____ Yes ____ No
If yes, indicate the last time the Applicant used the Home? _________________________

1. Parent/ Guardian #1
   Name: ____

   Address: ____

   City: __________________________ Postal Code: __________________________

   Phone Number: _________________ Work: ________________ Cell: ____________

2. Parent/ Guardian #2
   Name: ____

   Address (If different from above):____

   City: __________________________ Postal Code: __________________________

   Phone Number: _________________ Work: ________________ Cell: ____________

Is there Legal Guardianship in place from the courts? ____ Yes ____ No

In Case of Emergency, please list two additional emergency contacts:

1. Name: ____

   Home Phone Number: ______________ Work: _____________ Cell: __________

2. Name: ____

   Home Phone Number: ______________ Work: _____________ Cell: __________

CLSD/Family Services Worker Name: _______________________________________

Phone Number: _______________________

CLSD Combined Impact Score (under 18 years of age): _________________________

Natural Family _________ Approved Home _________ Foster Care __________

*** RRRC is not responsible for any lost, damaged, or stolen items while at the Respite Home ***

Medical Information

Pharmacy Name: ____

Address: __________________________________ Phone: _____________________

ALL MEDICATIONS MUST BE PROVIDED IN BLISTER PACKING BY PHARMACY THIS INCLUDES ALL OVER THE COUNTER MEDICATIONS

If Individual requires an Epipen you must include an Anaphylaxis Emergency Plan.

Are Immunizations up to date? ____ Yes ____ No

Is applicant susceptible to ear infections? ____ Yes ____ No

If yes, describe indicators and procedure to follow: ____________________________

____.

Please list all other medical conditions (i.e. Heart condition, Diabetes, etc.):

- ____
- ____

Does the applicant have a Specialized TLR Assessment completed, if yes please provide with application.

Does applicant require any specialized equipment? ____ Yes ____ No

If yes, please indicate: ____

____.

Communication

Non-verbal ____ Single Words ____ Sentences ____ Sign Language ____
PECS (Include with application) ____

Level of understanding:

____ Good ____Moderate ____Mild ____ Poor

Level of hearing:

____ Good ____Moderate ____Mild ____ Poor

Level of eyesight:

____ Good ____Moderate ____Mild ____ Poor

Eating

Feeds self: ____ Yes ____ No

Please indicate how to assist: ____

____.

Slow or fast eater please indicate: ____

Drinks from a cup or do they require special drinking considerations: _______________

____.

Food consistency: ____ pureed ____ diced ____ minced ____ finger foods ____ regular

Please list all known food likes and dislikes:

Likes:

____

____

Dislikes:

____

____

Special Diet: ____ Yes ____ No

Please indicate what Special Diet (i.e. Gluten free, soy based products, etc.): __________

____

____.

* Parents/caregivers to provide special dietary needs foods *

Please describe what a typical lunch looks like to take to their School or Day Program

____

____

Please list all food allergies and reactions: ____________________________________

____

____.

Toileting

Leve of assistance required:

____ Independent ____Partial Assistance ____ Total assistance ____Diapers/Attends

____ Prompting only

Expression or action used to indicate need: ____________________________________

____.

Bowel Care:

____ Independent ____Partial Assistance ____ Total assistance ____Diapers/Attends

____ Prompting only

Please list special equipment required (i.e. Commodes): ________________________

____.

Bowel/ Bladder routines: ____

____

____.

Hygiene

Does the applicant have a personal care plan: ____ Yes ____ No **(If yes please provide)**

Does Applicant	Independent	Partial Assistance	Total Assistance
Wash/dry hands & face			
Understand hot/cold			
Wash hair			
Brush teeth			
Bath			
Shave			
Handle menstrual needs			
Dress			
Undress			
Choose appropriate clothing			

Sleeping

Does the applicant require:

____ Regular bed ____Hospital bed ____Mattress on floor

Does the applicant nap: ____ Yes ____ No

Typical Bedtime: ________________

Typical wakeup time: ________________

Does applicant waken during the night: ____ Yes ____ No

Procedure to follow if wakens at night: ____

____

____.

Does the applicant require:

1. Night Light ____ Yes ____ No
2. Bedrails ____ Yes ____ No
3. Repositioning ____ Yes ____ No
   How often does applicant need to be repositioned during the night:
   ____.

Is applicant able to share a bedroom: ____ Yes ____ No

Day Program/School

Name of Day Program or School: ______________________________________

Address: ____

City: ____________________________ Postal Code: __________________________

Phone Number: _________________

Transportation arrangements

Name of transportation Company: ______________________________________

Phone Number: _________________

Typical pick up time: _____________________ am/pm

Typical drop off time: ____________________ am/pm

Family Guidelines for Respite Home

Is applicant allowed to leave the Respite Home unsupervised? ____ Yes ____ No

If yes please specify under what circumstances applicant is able to leave the Respite Home unsupervised: ____

____.

Any visiting restrictions, please list: ____

____.

Who has permission to pick up the applicant from the Respite Home, please list all:

- ____
- ____
- ____
- ____
- ____
- ____

Behaviour

Does the applicant have a Comprehensive Behaviour Support Plan: ____ Yes ____ No
If yes, provide most current plan

Does the Applicant have a Crisis Cycle Plan: ____ Yes ____ No
If yes, provide most current plan

Are there any restrictive procedures in place: ____ Yes ____ No
If yes, please provide with application

Will applicant indicate pain: ____ Yes ____ No

Explain indicators (verbal, physical prompts): ____________________________________

____

Does applicant understand danger: ____ Yes ____ No

If no provide list of safety precautions used: ______________________________________

____

Does applicant have any fears: ____ Yes ____ No

Please list fears: ____

____

Does applicant have behavioural concerns: ____ Yes ____ No

If yes please fill out following:
Triggers (What causes behaviour):

- ____
- ____
- ____
- ____

Is applicant abusive to self: ____ Yes ____ No

List Behaviours: ____

____

____.

Is applicant abusive to others: ____ Yes ____ No

List Beahviours: ____

____

____.

Does the applicant display any sexual behaviors which require additional supervision:

____ Yes ____ No

List Behaviours: ____

____

____.

How are all listed behaviours managed: ____

____

____

____.

Activities/Interests

Please list activities of interest:

- ___
- ___
- ___
- ___
- ___
- ___

List any special equipment required for outings (i.e. Car seat): ___

___.

Signatures

___	___
Signature of Applicant (Over 18)	**Date**
___	___
Signature of Parent/Caregiver	**Date**

Consents

Medical Consent

****If the individual is under the age of 18 or unable to give consent parents/guardians are to fill out consent form #2****

Over 18 years form:

1. I, ___________________________, the applicant hereby give consent to Regina Residential Resource Centre (RRRC) staff to administer or supervise the taking of all prescribed medications according to Doctor's instructions. I have provided all necessary written instructions for the administration and/or treatment and allow the staff to consult my Doctor as required.

I consent RRRC staff to take me to the emergency department of the nearest hospital or medical clinic for emergency treatment as required.

______________________________	______________________________
Signature of Applicant	Witness
______________________________	______________________________
Print Name	Date

17 Years and Under form:

2. I/We ____, parent(s)/guardian(s) of ______________________________ Hereby give consent to RRRC staff to give or supervise the taking of all prescribed medications according Doctor's instructions. I/We have provided all necessary written instructions for the administration and/or treatment and allow the staff to consult the applicant's doctor as required.

I/We consent RRRC staff to take the above named person to the emergency department of the nearest hospital or medical clinic for emergency treatment if required.

______________________________	______________________________
Signature of Applicant	Witness
______________________________	______________________________
Print Name	Date

Transportation Release

I/We ___________________________________, applicant/parent(s)/guardian(s) (of ____________________________) hereby consent RRRC staff to transport the above named in the agency or RRRC staff vehicle. I understand I am responsible to provide all equipment required for transportation.

I/We give consent for the above named to participate in any activities/outings planned by the Regina Residential Resource Centre staff. I/We understand activities will reflect the needs and interests of the individual. I/We understand a fee of $5.00/day will be charged.

________________________________ ________________________________
Signature Date

____
Print Name

Photograph Release

I/We, ________________________________, applicant/parent(s)/guardian(s) (of ______________________________) hereby consent _____________________________ be allowed to be photographed by RRRC staff. These photographs may be used in RRRC publicity and training information.

________________________________ ________________________________
Signature Date

____
Print Name

Release to Leave Unsupervised

I/We, _____________________________, applicant/parent(s)/guardian(s) (of _______________________________) hereby consent the applicant named above may leave RRRC unattended by RRRC staff under the following circumstances:
____
____.

________________________________ ________________________________
Signature Date

____
Print Name

Respite Home Application Consent to Share Information

Please complete fully

I/Parent(s)/Legal Guardian(s), ________________________________, of ____ hereby authorize you to release information from your records on the above named person to the Regina Residential Resource Centre.

It is my understanding all records released by you will be kept confidential by Regina Residential Resource Centre

Name of Day Program/School: ____

Teacher Name:

First Name: _________________________ Last Name: _________________________

Phone Number: (____)________________ Fax Number: (____)_________________

Email address of teacher: ____

_________________________________ _____________________________

Signature Date

_________________________________ _____________________________

Witness Date

Code of Conduct for Families/Caregivers of the Regina Residential Resource Centre's Homes

Below, find Regina Residential Resource Centre's Code of Conduct for Families/Caregivers.

Failure to adhere to this Code of Conduct may result in a loss of access to RRRC's facilities and services.

Conduct

I will:

- Respect the Staff and their authority in the day to day operations of the Respite Home
- Never engage in, or tolerate, offensive, insulting, or abusive language or behaviour
- Resolve conflicts without resorting to hostility or violence
- Take the time to count and compare medications on admission and discharge of each stay
- Notify Team Leads of any changes, including medications of the Individual, prior to admission
- Ensure all medications are blister packed by the Pharmacy prior to admission. All liquid medications must be provided with a Pharmacy label
- Sign and review all Incident Reports as prepared by the Respite Home
- Arrange all transportation prior to admission
- Respect the policies and procedures of the Respite Home as set out by RRRC
- Complete the Respite Home's Yearly Updates
- Make all arrangements with Home Care to provide additional medical requirements the Individual may require

I will not:

- Encourage any behaviour practices which would endanger the health, safety and wellbeing of Staff or other Individuals
- Ridicule Staff or Individuals
- Yell or give orders to the Staff or Individuals
- Dictate or use profane language toward Staff or Individuals

I agree, if I fail to abide by the aforementioned rules/guidelines as presented above, I will be subject to disciplinary action which could include, but is not limited to the following:

- Verbal warning
- Written warning
- Temporary suspension from usage of the Home

______________________________	______________________________
Printed Name of Caregiver	Signature of Caregiver
______________________________	______________________________
Printed Name of Individual	Date Signed