Enhanced Weekday Day Respite Referral Form: Pediatric

Thank you for your interest in respite at ErinoakKids, we look forward to welcoming your loved one. The following questions will help us ensure your loved one meets the criteria for this service. The information you provide will be kept confidential and will only be accessed by authorized staff for the purpose of providing respite services.

PACKAGE OPTION

Enhanced weekday day respite services are available at our **Brampton** site (10145 McVean Drive, Brampton). Services run on Wednesdays from 9:30 a.m. – 6:30 p.m. during your package dates. Packages include six (6) Wednesdays.

November & December Package (6 days total) Wednesdays, 9:30 a.m.-6:30 p.m.
Wed November 12
Wed November 19
Wed November 26
Wed December 3
Wed December 10
Wed December 17

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

1. Is this your child/loved one's first visit to our respite program?

   ☐ Yes
   ☐ No

2. Is your child/loved one under the age of 18 years?

   ☐ Yes
   ☐ No *(if no, please fill out the Enhanced Weekday Day Respite Adult form)*

3. Does your family live in one of the following regions? *(If none of the below, your loved one is not eligible for this service)*

   ☐ Halton
   ☐ Peel

4. Does your child/loved one live at home with their parent/guardian/foster parent?

   ☐ Yes
   ☐ No *(if no, your child/loved one is not eligible for this service)*

5. Does your child/loved one have an antibiotic resistant organism such as MRSA, VRE, or c-difficile?

   ☐ No
   ☐ Yes *(if yes, your child/loved one is not eligible at this time. Please contact Respite Admin at (905) 855-2690 ext. 2273 to discuss next steps with a nurse)*

6. Within the past 6 weeks has your child/loved one been admitted to hospital for concerns with mental health or escalated behaviour?

   ☐ No
   ☐ Yes *(if yes, your child/loved one is not eligible for this session, please consider applying for the winter session)*

7. Does your child/loved one have a MFTD (Medically Fragile Technologically Dependent) designation, complex medical needs and/or equipment to support physical needs requiring nursing support?

   ☐ Yes
   ☐ No

8. Does your child/loved one have challenging behaviour needs, autism, or other developmental disabilities that make it difficult to access community-based programs AND require medication administration or nursing support?

   ☐ Yes
   ☐ No

9. Does your child/loved one require more than one person to ensure their safety and participation at home or in school?

   ☐ Yes
   ☐ No

10. Does your child/loved one require supplemental oxygen?

    ☐ Yes
    ☐ No

11. Does your child/loved one have a tracheostomy or artificial airway?

    ☐ Yes
    ☐ No

12. Does your child/youth currently use a safety enclosed bed at home?

Standard Respite Bed

Safety Enclosed Bed

☐ Yes
☐ No

13. Does your child/loved one demonstrate aggression towards others (e.g., kicking, biting, hitting, etc.) or themselves (e.g., head hitting, self-biting, etc.) on a daily basis?

☐ Yes
☐ No

14. Does your child/loved one ever hit, break, or damage items in their environment (on purpose or by accident)?

☐ Yes
☐ No

CLIENT INFORMATION

Date of Birth (dd-mmm-yyyy) _____

Gender ☐ Male ☐ Female ☐ Prefer not to specify

Child's Name

Last Name _____ Middle Name (optional) _____

First Name _____

Health Card # (optional)_____Version Code _____

Address

Unit#_____Street#_____Street Name _____

City_____Postal Code _____

Parent / Legal Guardian Names

1. **Person to Notify *(primary contact - will be the only person notified for services)***

Last name_____First Name _____

Relationship _____

Phone #1_____Phone Type Choose from below:

Phone #2_____Phone Type Choose from below:

Email _____

Address ☐ Same as client ☐ Different from Client *If different from client, please fill out below*

Unit#_____Street#_____Street name _____

City_____Postal Code _____

2. **Next of Kin *(secondary contact - optional)***

Last name_____First Name _____

Relationship _____

Phone #1_____Phone Type Choose from below:

Phone #2_____Phone Type Choose from below:

Email _____

Address ☐ Same as client ☐ Different from Client *If different from client, please fill out below*

Unit#_____Street#_____Street name _____

City_____Postal Code _____

Who does your child/loved one live with:

☐ Both parents ☐ One parent ☐ Foster Parent

☐ Other (specify) _____

Primary Language spoken in the home _____

Are Interpreter Services required? ☐ Yes ☐ No ☐ Unsure If yes, state language/ASL _____

Children's Protective Services, Agency Name: (optional) _____

Caseworker's Name (optional) _____ Phone Number (optional) _____

Diagnosis ☐ No ☐ Yes if yes, identify diagnosis: _____

Allergies ☐ No ☐ Yes if yes, specific allergy(s): _____

Is an EpiPen required ☐ No ☐ Yes If yes, specify EpiPen allergy _____

CONSENT

This information is being submitted with the knowledge and consent of the parents/legal guardians.
By providing the contact information with the form(s), you consent to receiving information about your service at ErinoakKids by email, SMS/Text and other electronic means.

☐ Yes ☐ No

ErinoakKids also shares information on new service offerings, fundraising initiatives, free events offered at ErinoakKids and surveys by email, post, SMS/text and other electronic means. ErinoakKids will always treat your personal details with the utmost care and will not share or sell your personal information. You may unsubscribe from receiving communications from ErinoakKids at any time. We are committed to keeping your information safe and confidential. We follow the rules set out in law about collecting, using and disclosing your personal information. For more information, please review our privacy policies publicly posted at https://www.erinoakkids.ca/privacy.

☐ Yes ☐ No

If you have any questions regarding our respite services, please contact our Intake team at (905) 855-2690 option 1.

Thank you. Please submit the completed form