APPLICATION/ADMISSION INFORMATION PACKAGE

NAME OF PROGRAM: _____

Name: _____ _____ **D.O.B.** __/____/____ **Gender**: M / F
Last First day / month / year

Home Address: _____

_____ **Postal Code:** _____

Telephone #: _____

Family/Caregiver- Name: _____

Address: _____ **Postal Code:**_____

Telephone #: _____ **Cell #:** _____

E-mail address: _____

Name of Referring Agency: _____

Medical and Physician Information

Diagnosis: _____

Health Card No. _____ **Version:** _____
Please provide original card, or photocopy

Family Physician: _____ **Tel. No.** _____
Address: _____

Psychiatrist: _____ **Tel. No.** _____
Address: _____

Dentist: _____ **Tel. No.** _____
Address: _____

Other Specialist(s) _____ **Tel. No.** _____
Address: _____

School: _____ **Tel. No.** _____
Address: _____

Medications

Is the individual currently taking medications? Yes____ No____
If applicable, please attach a list of current medication, doses, etc.
Does the individual self-administer their own medication? Yes____ No ____

Medical Treatments Yes____ No____
If yes, please specify: _____
_____
_____

Colostomy Care: Yes ____ No____
Special Instructions / Comments: _____
_____
_____

Gastric Tube Feeding: Yes ____ No____
Special Instructions / Comments: _____
_____
_____

Immunizations

Are the individual's immunizations current? Yes____ No____
Please attach a copy of immunization record **(required for the Respite, STATE, Safe Bed programs)**

Drug Allergies Yes ___ No ___
If yes, please specify: _____
_____
_____

Food Allergies Yes ___ No ___
If yes, please specify: _____
_____
_____

Seizures Yes ___ No ___

Description of Seizures – i.e. Type (e.g. Grand Mal, Petit) and Duration
_____
_____
_____

What is the individual's seizure protocol? *(Please provide written instructions)*
_____
_____
_____
_____
_____

Other Medical Considerations:	**Yes**	**No**	**Comments**
Diabetes	____	____	_____
Heart Problems	____	____	_____
Eating Disorders/Swallowing Problems	____	____	_____
Risk of Choking	____	____	_____
PICA (eats inedible objects)	____	____	_____
Hepatitis B Carrier	____	____	_____
Respiratory Problems	____	____	_____
History of Head Injury	____	____	_____
Kidney Problems	____	____	_____
Incontinent – Bladder	____	____	_____
- Bowel	____	____	_____

ACCESSIBILITY

Vision/Hearing:	**Yes**	**No**	**Comments**
Visual Problems	____	____	_____
Wears Corrective Lenses/Contacts	____	____	_____
Hearing Problems	____	____	_____
Wears a Hearing Aid	____	____	_____

Motor Skills	**Yes**	**No**	**Comments**
Sits Independently	____	____	_____
Climbs Stairs	____	____	_____
Walks	____	____	_____
Uses Walker	____	____	_____
Uses Wheelchair	____	____	_____
Lift/sling	____	____	_____
Special equipment required.	____	____	_____

If deemed necessary, clients that are wheelchair dependent will be transferred using mechanical lifts and slings (for the Respite, STATE, Safe Bed programs)

_____

_____

Communication	**Yes**	**No**	**Comments**
Verbal	____	____	_____
Uses sentences	____	____	_____
Uses words	____	____	_____
Uses sign language	____	____	_____
Understands what is said?	____	____	_____
Languages spoken in the home	____	____	_____
Other languages spoken	____	____	_____
Other languages understood	____	____	_____

Other communications tools (please list):

_____

_____

Behaviour

Does this individual have a current behavioural intervention program? If so, please provide us with a copy.

Aggression Towards Others: Yes ___ No ___

Please describe: _____

How are behaviours dealt with? _____

Aggression Towards Self? Yes ___ No ___

Please describe: _____

How are behaviours dealt with? _____

Aggression Towards Environment? Yes ___ No___

Please describe: _____

How are behaviours dealt with? _____

Wanders off? Yes ____ No_____

Please describe: _____

How are behaviours dealt with? _____

Emotional Profile

	Yes	No		Yes	No
Anxiety	___	___	Phobias	___	___
Confident	___	___	Shy	___	___
Happy	___	___	Withdrawn	___	___
Sociable/Friendly	___	___	Poor Self Concept	___	___
Obsessive Behaviours	___	___	Difficulties with depression	___	___
Attention Seeking	___	___			

Comments: _____

Religion

Denomination _____

Specific requests / arrangements: _____
_____

School/Day Program

Attends ____ Day Programs ____School ____Work/Workshop
Please Describe (Name, Type, Level of Participation, etc.): ___
_____
_____
_____

Community Awareness

	Yes	No
Sexually appropriate	___	___
Can use public transportation	___	___
Understands the concept of money	___	___

Family History/Relationships:

With whom/where does the individual currently reside? _____
_____
Parents: _____
_____
_____
Siblings: _____
_____
_____
Grandparents: _____
_____
_____
Is there any history of psychiatric illness in the family? _____
If yes, please describe: _____
_____
_____
_____
_____
_____
Are there any medical conditions in the family?
_____
_____
_____
_____
Additional Information_____
_____
_____

Mealtime Please list preferred foods: _____
_____

Please list food dislikes: _____
_____

If specific diet is required, please describe:
_____

Specify Food Consistency
Regular: ____ Chopped: ____ Minced: ____ Pureed: ____

Eating Skills

Independent	___	Semi-Independent	___	Dependent	___
Hand-over-hand	___				
Uses Spoon	___	Uses Fork	___	Uses knife	___
Right handed	___	Left handed	___	Drinks from cup	___
Drinks from straw	___	Uses regular chair	___	Sometimes chokes	___

Dressing
Independent ___ Semi-independent ___ Dependent ___

Sleeping

Lights on:	Yes___	No___	Doesn't matter	___
Sleeps in	Yes___	No___	Doesn't matter	___
Sleeps until	_____ a.m.			
Sleeps with door open	Yes ___	No ___	Doesn't matter	___
Wakes up at night	Yes ___	No ___	Not usually	___

If the individual wakes throught the night, what should be done?
_____
_____
_____

Specific Information on the Following

1. Bathing & Showering _____
_____
_____
_____

2. Toileting:
Bladder Function: _____
_____
Bowel Function: _____
_____

3. Dental Care: _____
_____

4. Other Hygiene Considerations/Concerns: _____
_____

DAILY ROUTINES

Usual Routine in the Morning:

Usual Routine in the Afternoon:

Usual Evening and Bedtime Routine:

Strengths the individual has:

_____
_____
_____

Specific Likes & Dislikes of the individual:

_____
_____
_____
_____

Individual Goal Plan

Please complete a goal choice to be worked on while at Respite. Goals should be related to recreational

Goals related to recreation:

_____
_____
_____
_____
_____
_____

Other: _____
_____
_____

Name of the person completing this application _____

Signature of the person completing this application _____

Date: _____