Telephone (519-929-9494)
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www.armisaelcare.ca

CHRISTIE OAKS CARE HOME RESPITE
INTAKE/REFERRAL FORM
CONFIDENTIAL

Date: _____

Residents Name: _____

Address: _____

Phone_____ DOB: _____ M/F _____

POA/Caregiver _____

Phone: _____

Address if different from residents: _____

Emergency Contact: _____

Health Care Number: _____

Allergies; _____

Special Diet: _____

Medical diagnosis: _____

_____

_____

Activities of daily living provided	Manage independently	Needs supervision	Needs assistance	Does not apply
Bathing/Hair Care				
Shaving				
Skin Care				
Oral Care				
Toileting/Depends/Diapers				
Dressing				
Eating/Drinking				
Walking/Ambulating (uses cane, wheelchair or other support?)				
Stair Climbing				
Medication Administration				

Does this person have special dietary requirements or restrictions?	♦ Yes ♦ No If yes, describe.			
Does this person use oxygen?	♦ Yes ♦ No If yes, describe.			
Does this person wear a C-Pap or Bi-Pap while sleeping?	♦ Yes ♦ N			
Does this person have a history of seizures?	♦ Yes ♦ No If yes, describe the type and frequency, and provide a copy of the seizure protocol. If yes, what is the date of the last seizure?			
Does this person use special or adaptive equipment?	♦ Yes ♦ No (Include walker, wheelchair, assistive technology, hearing aids, etc.) If yes, describe.			
Does this person require transferring by a support person or support staff?	♦ Yes ♦ No			
Has this person been hospitalized in the last year?	♦ Yes ♦ No If yes, describe the reason(s) for hospitalization and/or the situation which required hospitalization.			
Behavior Information				
Does this person have a behavior plan?	♦ Yes ♦ No If yes, attach a copy of the plan.			
Has this person attempted suicide in the last year?	♦ Yes ♦ No If yes, provide date(s) and details.			
Behaviors Exhibited	yes	No	frequency	Additional info
Yelling/Shouting/Screaming				

Biting				
Hitting				
Restlessness				
Wandering				
Aggression				
Forgetfulness (especially showering/eating)				
Inappropriate Sexual Behavior				
Exit seeking				
Calling out				
Swearing				

Primary Diagnosis (please check all that apply).

2. Does the patient require care that should be delivered by a skilled health care professional during respite hours (such as medication administration, G-tube feeding, injections, catheter care, etc.)?
♦ Yes ♦ No If yes, provide details.
_____
_____
3. Please list any and all medications prescribed to the patient.
_____
_____
_____

Signature of POA _____

Date: _____

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