Day Respite Referral Form

All fields are required unless marked "optional"

Please note that payment for all requested sessions are due on booking. This cost to families represents 7% of the total cost of providing respite care, with the rest subsidized by donations. Fees are necessary to secure the resources and commit to staffing. Assistance is available for families in need, please see our Resources page for more information.

GENERAL CONSENT

This request is being submitted with the knowledge and consent of names parents/legal guardians.
Have parents provided implied consent to information collection as per ErinoakKids Privacy Policy available at: https://erinoakkids.ca/about-us/about-erinoakkids/accountability/policies/privacy-and-confidentiality

Consent Received: ☐ Yes ☐ No If No, ErinoakKids will not process this referral

ERINOAKKIDS' RESPITE SERVICES STREAMS

Please access the ErinoakKids website for descriptions and eligibility criteria for each respite service stream https://www.erinoakkids.ca/all-services/familysupports/respite-services

Day Respite

Please fill out the following four questions to determine eligibility for Saturday Day Respite Services:

Is your family member under the age of 18 years?

- ☐ Yes
- ☐ No *(if no, please fill out 18+ form)*

Do you reside in one of the following regions? *(If none of below, family member is not eligible for ErinoakKids Respite Services)*

- ☐ Halton
- ☐ Peel

Does your family member reside at home with their parent/caregiver?

- ☐ Yes
- ☐ No *(if no, family member is not eligible for ErinoakKids Respite Services)*

Does your family member have challenging behaviour needs,autism, other developmental disabilities that make it difficult to access community based programs?

- ☐ Yes
- ☐ No *(if no, family member is not eligible for ErinoakKids Respite Services)*

CLIENT INFORMATION

Date of Birth (dd-mmm-yyyy) _____

Gender ☐Male ☐Female ☐Other

Child's Name
Last Name _____
First Name _____ Middle Name (optional) _____
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 your family member lives 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_____

SPECIAL NEEDS INFORMATION

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

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

Diagnosis ☐Yes ☐No If yes, identify diagnosis _____

Identify area of concern: _____

Allergies ☐Yes ☐No If yes, specify allergy(s) _____

Epipen required? ☐Yes ☐No If yes, specify Epipen allergy _____

BEHAVIOURAL NEEDS

Does your family member demonstrate any of the following

Does your family member demonstrate aggression towards others?

- ☐ 1 to 3 times/day
- ☐ 1 to 3 times/week
- ☐ 1 to 3 times/month
- ☐ None of the above

Does your family member demonstrate aggression towards themselves?

- ☐ requires medical treatment
- ☐ requires first aid-treatment
- ☐ does not require treatment
- ☐ None of the above

Does your family member try to leave the house on their own?

- ☐ 1 to 3 times/day
- ☐ 1 to 3 times/week
- ☐ 1 to 3 times/month
- ☐ None of the above

FUNDING

How will you be paying for your Respite stay?

☐ Special Services at Home (SSAH) where ErinoakKids is your Transfer Payment Agency (TPA)

☐ Parent Funded – self pay

REFERRAL SOURCE

☐ Parent / Guardian ☐ Medical ☐ Community Agency ☐ Other

Referral Source Name and Contact Information

_____

_____

_____

If you have any questions regarding your family member's eligibility, please contact our respite administration at (905) 855-2690 x2273

Thank you. Please submit the completed form.