# 18+ Respite Referral Form

All fields are required unless marked “optional”

## 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/family-supports/respite-services

## 18+

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

Is your family member 18 years or older?

- ☐ Yes
- ☐ No *(if no, please fill out MFTD or N-MFTD form)*

Does your family member reside in the Province of Ontario?

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

Does your family member have significant physical or developmental disabilities requiring nursing support?

- ☐ Yes
- ☐ No

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

- ☐ 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 _____

## DATE SELECTION

Please select your top 3 choices per quarter (three month period)

### 18+

**Quarter 3** (October - December 2023)

First choice: Choose from below:

Second choice: Choose from below:

Third choice: Choose from below:

**2024 Dates:**

**Quarter 4** (January - March 2024)

First choice: Choose from below:

Second choice: Choose from below:

Third choice: Choose from below:

**Quarter 1** (April - June 2024)

First choice: Choose from below:

Second choice: Choose from below:

Third choice: Choose from below:

**Quarter 2** (July - September 2024)

First choice: Choose from below:

Second choice: Choose from below:

**Quarter 3** (October - December 2024)

First choice: Choose from below:

Second choice: Choose from below:

Third choice: Choose from below:

**Thank for outlining your priority dates. We will work diligently to accommodate your dates as requested.**

## MEDICAL NEEDS

Does your family member use equipment or require respiratory support to help with their breathing in the day? Examples include tracheostomy, BiPap, CPAP, oral or trach suctioning, cough assist or oxygen.

☐ Yes ☐ No If Yes, describe: _____

Which type of bed does your family member use?

☐ safety-enclosed bed (twin bed with 1-3 ft rails)
☐ standard bed (twin bed with 6 inch rails)

## 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.