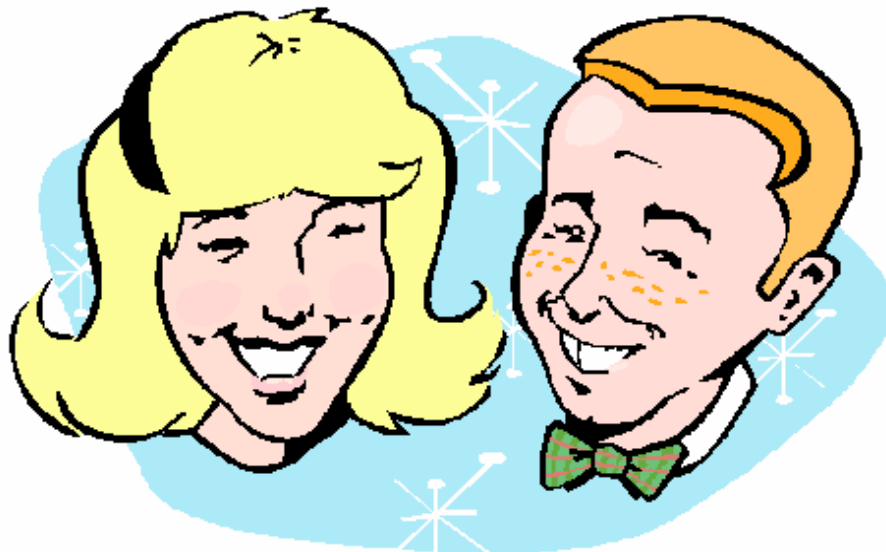


Let Me Introduce Myself



Hi, my name is: _____

Completed on: _____



This booklet has been designed by the Huron Respite Network.
The booklet will be used by participants, families, Host Families, In-Home Respite Providers
and other service providers as directed by the participant and/or their family.
All information is confidential.



The Huron Respite Network

15 Rattenbury St. E.
P.O. Box 1581
Clinton, Ontario N0M 1L0
Phone (519) 482-3115
Fax (519) 482-7667
e-mail huronrespitenet@tcc.on.ca
www.huronrespitenetwork.ca

LET ME INTRODUCE MYSELF

Hi my name is: _____ You may call me: _____

My birthday is: _____ My phone number is: _____

I live at: _____

(Street Address and/or Mailing Address)

(Town and Province)

(Postal Code)

And I live with: _____

Sex: _____ F/M

My height is: _____ My weight is: _____ My eye colour is: _____

In case of an emergency please contact:

1. _____
(Full Name) (Relationship) (Day Phone#) (Night Phone #)
2. _____
3. _____

Health Card #: _____ Private Health Insurance Policy #: _____

Name of Insurance Company: _____

A PICTURE OF ME

Date of Picture: _____



I have a:

- Physical Disability
- Acquired Brain Injury
- Hearing Impairment
- Other: specify:
- Developmental Disability
- Visual Impairment
- Sensory

- I take Medication (Includes Birth Control, See form)
- I have a special diet (see form)
- Other (Specify):

MY UNDERSTANDING AND BEHAVIOUR

- I understand all that you say
- I can read
- I can write
- I am sexually active
- Other (Helpful ideas for communication/gestures etc.) Specify:
- I understand some of what you say
- I react to touch
- I react to new carers (positively/negatively)

- I behave in a manner deemed to be unusual/inappropriate. (Please explain)

- The best way to deal with my behavior is:

I may:

- Wander
- Fire lighting
- Aggressive to others
- Damage Property
- Leave
- Other Specify:

COMMUNICATION

I communicate best:

- Language(s) spoken/understood:
- Please explain to me what you are doing, or planning to do. I may understand you however I may not be able to speak to you.

I respond by:

- speech/verbal
- signing (ASL)
- eye pointing
- communication aid/device (specify)
- gestures
- yes/no response
- auditory scanning
- facial expressions
- I have no reliable or consistent response
- emotional state/ behavior

I will indicate the following:

- yes
- no
- toilet
- other: (specify)
- happy
- eat
- pain/discomfort
- worried
- drink

When you meet me, I respond more positively if you:

MY DAILY LIVING SKILLS

Communication

- Verbal
- Signing
- Indicates his/her needs
- Responds to Yes/No
- Comprehends simple commands
- Does not respond
- Communication Aid (specify)

Interaction with Others

- Interacts voluntarily
- Accepts Interaction
- Needs Encouragement
- Dislikes Interaction

Personal Hygiene

- Fully Independent
- Semi Independent
- Needs Full Assistance

Mealtime

- Independent
- Needs Assistance
- Uses Aids

Dressing

- Independent
- Semi-Independent
- Needs Total Assistance

Mobility

- Independent
- Walks with Assistance
(cane / walker)
- Wheelchair
- Unsteady & Easily Falls

SEATING

- I can sit independently
- I like to sit on e.g.: beanbag, high back chair, wheelchair, pillow
- Other Specify:

MEALS

- I have brought with me: e.g. special cup, utensils
- My usual method of nutrition: e.g. oral, gastrostomy, naso-gastric

If tube fed please see Nutrition Plan attached

DRINKING

- I need assistance
- I drink from: e.g. bottle, feeding cup, cup with lip, straw
- My drink needs to be thickened
- I favorite drink is: e.g. Milk

EATING

- I require special dietary requirement to be followed (e.g. Diabetes, food allergies)?

Please explain what is it? (i.e.: types of food, semi/solid/liquid etc.)

- I need assistance
- My food needs to be: e.g. cut up, soft, pureed/vitamized, hot,
- Other needs for eating: i.e. high chair, pillow, quiet room

Please explain:

Food I like:

Food I do not like and/or cannot have:

Bowel:

- I use my bowels (how often)
- I need assistance: e.g. Laxatives, suppositories, enemas

Bathing:

- I prefer to bathe
- I can bathe independently
- I need equipment:
- I prefer to shower
- I need assistance

Specify:

EPILEPSY

- I have epilepsy

Description and frequency of seizure:

If I have any other kind of seizure, or if my seizures are occurring more frequently, it will be important to let my doctor know.

My seizures are most likely to happen if: e.g. I have not taken my medication, I am upset, worried, very tired, have not eaten, it is too hot, too many bright lights, horrible smells and loud noises

I need to take my anti-epileptic medication exactly at the time my doctor has said. It must coincide with my routine and not someone else's, otherwise I am more likely to have a seizure. I need someone to stay with me if I have a seizure. If I am fasting before an operation, it is essential that I get my usual dose of anti-epileptic medication.

My regular neurologist/treating doctor is: _____

Telephone: _____

MEDICATION

For medication requirements and dosage, please complete the attached Medication Form.

- I take capsules
- I take tablets: e.g. Crushed, mixed with food, placed on tongue
- I take mixture: e.g. With a spoon, syringe, mixed with drink
- I use rectal medication
- I am allergic to this medication: _____

PERSONAL INTERESTS

- I like music.

My favourite type of music and artist is:

- I like pets?

My favourite animals are:

My favourite activities are: (i.e. games, puzzles etc)

My interests and/or hobbies are: (i.e. reading, stamp collection etc)

My favorite sport and/or team are:

I have education and/or training in:

My special skills are:

Activities I would like to experience are: (please list if there is more than one).

I would like to learn about or how to do: (i.e. skills, hobbies etc.)

Other relevant information/comments pertaining to my support and/or care.

My feeding method is: e.g. Bolus, gravity, continuous pump, G tube, JG Tube
Please explain

The times I like to eat are: (i.e.. Mealtimes/night only)

Formula: _____

Feed volume per day: _____

Feeding rate: _____

Additional water: _____

Water flush amount: _____
(after each feed, to ensure tube does not block)

Total volume per day: _____

Nutrition information: (cal/kilo joule) _____

Date of tube insertion: _____

Hospital: _____

Type of tube: _____

Size: _____

Amount of water in balloon: _____

Doctor: _____

Dietician: _____

Speech Pathologist: _____

Occupational Therapist: _____

Physical Therapist: _____

Teacher: _____

Other: _____

MY TYPICAL DAY

TIME	WEEKDAY	WEEKEND
6:00 am		
7:00 am		
8:00 am		
9:00 am		
10:00 am		
11:00 am		
12 noon		
1:00 pm		
2:00 pm		
3:00 pm		
4:00 pm		
5:00 pm		
6:00 pm		
7:00 pm		
8:00 pm		
9:00 pm		
10:00 pm		
11:00 pm		
Midnight		
1:00 am		
2:00 am		
3:00 am		
4:00 am		
5:00 am		

Weekly Events:

1. _____
 2. _____
 3. _____
- | | | |
|-----------------------|-------------------|----------------|
| Event/Location | Days/Times | Phone # |
|-----------------------|-------------------|----------------|

I require support to attend/participate in the above activities.

My support workers are:

_____	_____	_____
Name	Program	Phone #



HURON RESPITE NETWORK

AUTHORIZATION TO TRANSPORT, PROVIDE MEDICAL CARE

Name of Participant (s): _____

For the period from: _____ to _____

MEDICAL:

In case of medical emergency, I/we hereby authorize the Respite Provider to hospitalize the above-named and secure treatment deemed as necessary by attending medical staff, including injections, blood transfusions, anesthesia, surgery and transport by ambulance.

LIABILITY:

I/we will not hold the Huron Respite Network Respite Provider liable should any accident, illness, property damage or injury occur. I understand that it is recommended that I/we obtain and maintain general liability insurance acceptable in Ontario, for an amount not less than \$1,000,000 per occurrence.

TRANSPORTATION:

I/we hereby authorize the Respite Providers to transport _____.

I accept full responsibility should an accident occur while _____

is being transported. I will not hold the Huron Respite Network or the participating agencies or the Respite Provider liable.

Participant's Health Card Number: _____

Emergency/Serious Occurrence Procedure

In the event of an emergency or serious occurrence the following procedure is to be followed.

Contact Emergency Service. i.e.. ambulance, police, doctor etc.

Parents of child.

If unavailable, then first contact person.

If first contact person is unavailable, then notify second person.

Contact Coordinator or leave a message in any event on:

Office: 519 482 3115 Mon - Fri 8:30 am to 4:30 pm and/or

On Call: 519 440 6880 after hours and on weekends.

Next of Kin/ Close Family Friends: (for emergency purposes)

Name:

HOME #:

WORK #:

Depending on the circumstances of the accident the order in which the above is conducted is left to the discretion of the carers involved.

Signature

Relationship

Date

Witness

Consent must be signed by the child over 12 years of age or in case of a minor by the parent or legal guardian, whichever is the appropriate legal authority. In the case of a child over 12 years of age who has a physical or developmental disability to such a degree as to be incapable of giving consent, the parent/guardian may authorize this consent.

Revised 03/02/04

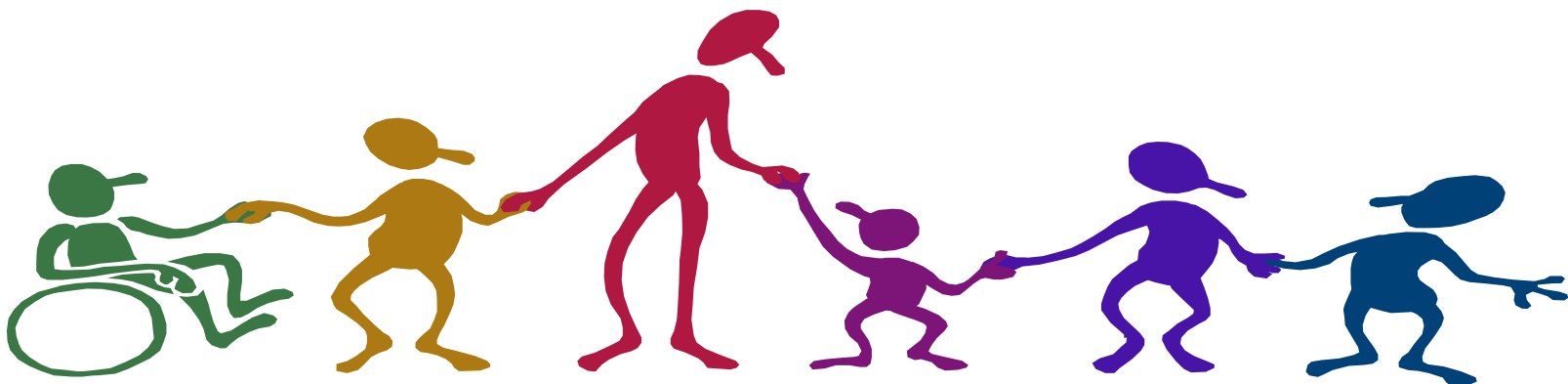
MEDICATION ADMINISTRATION FORM



ALL MEDICATION MUST BE IN ORIGINAL CONTAINER AND CLEARLY NAMED.

Medication	Dosage	Time of Day	How administered

Participant's/Parent's/Guardian's Signature: _____ Date: ___ / ___ / ___



HURON RESPITE NETWORK



AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION

FOR PEOPLE REQUESTING RESPITE

I _____ give the Respite Coordinator permission to release and/or obtain information concerning _____ with the following agencies, programs and/or individuals indicated by my initials:

Agency/program	Initial
Community Living – Central Huron	_____
Community Living – South Huron	_____
Wingham and District Community Living Assoc.	_____
Community Support for Families	_____
Familyhome Program	_____
Huron Safe Homes for Youth	_____
Children’s Aid Society	_____
Huron Perth Crisis Intervention Program	_____
Community Care Access Centre for Huron	_____
Community Resource Facilitator – ACL	_____
Adult Protection Services	_____
Other (specify)	_____
_____	_____
_____	_____
_____	_____

I am also aware that monthly report forms from the Respite Provider will be forwarded to the Respite Coordinator, the home agency, the placement agency and the Huron Perth Crisis Intervention Program (to ease the placement process in the event of an emergency). An example is attached to this consent form. These reports are considered confidential.

Placing Agency _____ Home Agency _____

This consent is effective from _____ to _____

Signature of Participant/Parent/Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

SUMMARY OF KEY POINTS:

1.

2.

3.

4.

5.

Participant Signature: _____ Date: _____
Parent/Guardian signature: _____ Date: _____

