

**Alliance for Community Respite Care - Referral Information**

**Date:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

**Child's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

**Caregiver's Name:** \_\_\_\_\_

**# of Caregivers at Home:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**# of Siblings and Ages:** \_\_\_\_\_

**Type of Respite Requested (day, evening, emergency, overnight, other):** \_\_\_\_\_

**Place of Service:**  In Home  Out of Home  Both/Either

**Health Insurance:** \_\_\_\_\_

**Disability or Chronic Medical Problem (including mental health diagnosis):**

**Medical History: (current health status, medications, medical conditions and equipment)**

**Other special training required/needed by provider (example: seizure disorder, diabetes)**

**Does medication need to be dispensed during time of services?**  Yes  No

**Is special nursing care needed?**  Yes  No **Ambulatory care?**  Yes  No

**Will physical assistance be needed?**  Yes  No **If yes - Height** \_\_\_\_ **Weight** \_\_\_\_

**Visually Impaired?**  Yes  No **Hearing Impaired?**  Yes  No

**Verbal?**  Yes  No

**Personal Hygiene: Use of Diapers**  Yes  No

**Is transportation needed during respite?**  Yes  No

**Special Diet/Feeding Needs:**  Yes  No **If yes, please specify** \_\_\_\_\_

**What other community programs are you involved with ?** \_\_\_\_\_

**Anything else?** \_\_\_\_\_