



PALLIATIVE RESPITE APPLICATION FORM

Name of Child: _____ **Date of Birth:** _____ / _____ / _____
MMM / DD / YYYY

Nickname: _____ **Health Card Number:** _____

Parent(s)/Guardian(s): _____ **Extended Family Members:** _____

Sibling(s) - include gender(s) and age(s): _____

Address of Family:

Street _____ City/Town _____ Postal Code _____

Home phone _____ Alternate phone _____ Email address _____

Address of Child : (Check if same as above)

Street _____ City/Town _____ Postal Code _____

Home phone _____ Alternate phone _____ Email address _____

Key Contact Information:

Contact Number

Primary Physician:		
Palliative Physician:		
CCAC Case Manager:		

Summary of Child's Medical Condition (include all diagnoses):

Recent Illnesses (immediate 6 months, including hospitalizations):

Allergies:

Technological Requirement(s):

Outline of Child's Daily Care Requirement(s):

Relevant Family Social History:

Spiritual Beliefs / Alternative Therapies:

Favourite Toys / Activities:

Attending School: No Yes **Name of School and District:** _____

Interested in the following type of respite (choose all that apply):

- Overnight Fall / Winter weekend
- Overnight Summer weekend and/or weeklong
- Specific Dates: _____
- Long weekend

How did you hear about The Darling Home for Kids?

Please return completed application form to Sharleen Sun, Clinical Manager, either by mail, fax or email sharleen@darlinghomeforkids.ca. You will be contacted after your application has been reviewed.