HOSPICE PALLIATIVE APPLICATION FORM

Thank you for your interest in The Darling Home for Kids. Our Home provides hospice palliative services to families of children aged 0 to 19 who have a life-limiting or life-threatening illness.

To access our hospice palliative program, children must require ongoing nursing interventions and monitoring and be demonstrating a progressive decline. Medical care requirements include but are not limited to tracheostomy care, administration of gastrostomy or jejunostomy tube feeds, ostomy care, mechanical ventilation, complex seizure management and pain and symptom management.

Our hospice palliative program includes short term respite (weekend or weeklong), transitional support from hospital to home, as well as end-of-life care.

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

Nickname: ____________________ **Health Card Number:** ____________________

Name(s) of Parent(s)/Guardian(s):

____

____

Wardship status: ☐ N/A ☐ Society ☐ Crown

Name(s) of Sibling(s) - include gender(s) and age(s):

____

____

____

Address of Parent(s)/Guardian(s):

Street ____________ City/Town ____________ Postal Code ____________

Home phone ____________ Alternate phone ____________ Email address ____________

Preferred means of contact: ☐ *Home phone* ☐ *Alternate phone* ☐ *Email*

Address of Child: *(☐ Check if same as address of family)*

Street ____________ City/Town ____________ Postal Code ____________

Home phone ____________ Alternate phone ____________ Email address ____________

Residing in the region of: ☐ Halton ☐ Toronto ☐ Niagara ☐ Peel ☐ Hamilton ☐ Other: ____________

Child's Underlying Medical Diagnosis/Diagnoses (if known):

____

____

5657 15th Side Road Milton, ON L9E 0C8
Telephone: 905 878 7673 Fax: 905 878 9886
info@darlinghomeforkids.ca

Services Requested
(*Check all that apply*)

- ☐ Palliative-Respite
  - ☐ *Overnight weekend* ☐ *Overnight weeklong*
- ☐ Transitional Support
  - *Hospital discharge date (if known):* ______________________
- ☐ End-of-life Care

For Palliative-Respite Applications

Has your child participated in an out-of-home respite program before? ☐ Yes ☐ No

Where else has your child attended out-of-home respite?

____

____

Summary of Child's Medical Fragility and Technological Requirement(s):

- ☐ *Seizure disorder*
  - ☐ *daily* ☐ *2-4/day*
  - ☐ *5-10/day* ☐ *>10/day*
- ☐ *Moderate to severe dystonia*
- ☐ *Hypotonia or hypertonia*
- ☐ *Immunocompromised*
- ☐ *Tracheostomy/artificial airway*
- ☐ *Oxygen administration*
- ☐ *Ventilator dependent*
- ☐ *Suctioning*
  - ☐ *daily* ☐ *every 4-8 hrs*
  - ☐ *every 2-3 hrs* ☐ *hourly or more*
- ☐ *Moderate to severe hearing impairment*
- ☐ *Moderate to severe visual impairment*
- ☐ *G-tube, GJ-tube, or J-tube*
- ☐ *Colostomy, caecostomy or malone*
- ☐ *Urostomy,vesicostomy, mitrofanoff*
- ☐ *TPN*
- ☐ *Other technological requirement(s):* ____
- ☐ *Other medical fragility:* ____

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

- ☐ *Medication administration*
  - *Route*
    - ☐ *Oral* ☐ *via feeding tube*
    - ☐ *Nebulizer* ☐ *Injections*
  - *Frequency*
    - ☐ *1 - 3x /day* ☐ *4 - 6x /day*
    - ☐ *> 6x /day*
- ☐ *Enteral feeding*
  - ☐ *Overnight feeds*
  - ☐ *Special formulation*
  - ☐ *Continuous feeds*
- ☐ *Airway management*
- ☐ *Chest physio/suctioning*
- ☐ *Seizure management*
- ☐ *Continuous pulse oximetry*
- ☐ *Daily vitals*
- ☐ *Catherization*
  - ☐ *as needed only*
  - ☐ *2 - 4x/day*
  - ☐ *indwelling*
- ☐ *Pain and symptom management*
- ☐ *Other daily requirement(s):* ____

Recent Illnesses (immediate 6 months, including hospitalizations):

____

____

____

Relevant Family Social History:

____

____

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Attending School: ☐ Yes ☐ No **Name of School:** ____________________

School District: ____________________

Does your child receive nursing support at school? ☐ Yes ☐ No

Physician Information

Primary Physician: ____________________

Tel: ____________________

Palliative Physician: ____________________

Tel: ____________________

CCAC Case Manager

CCAC Case Manager: ____________________

Tel: ____________________

I give permission for The Darling Home for Kids to contact my child's physician(s) and CCAC Case Manager for more information. ☐ Yes ☐ No

How did you hear about The Darling Home for Kids?

____

____

____

Any other pertinent information relevant to your application:

____

____

____

Name of person completing application: ____________________

Relationship to child: ____________________

Date of completion: ____________________

Signature: ____________________

To apply, please submit the following items either by mail, fax, or email with subject title "Hospice Palliative Application":

1) This completed Hospice Palliative Application Form
2) A copy of your child's medical history, which may be from a recent hospital discharge summary, physician's office, or any other medical history document

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