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 pallaitive 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):

_____

_____

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

_____

_____

_____

Wardship status: ☐ N/A ☐ Society ☐ Crown

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 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: _____

HCCSS Information HCCSS Care Coordinator: _____

Tel: _____

I give permission for The Darling Home for Kids to contact my child's physician(s) and HCCSS Care Coordinator(s) 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 "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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