45 JACK LAYTON WAY ● TORONTO, ONTARIO ● M4M 0B7 ● PHONE: 416-363-9196 ● FAX: 416-363-6153

emily's house
Children's Hospice

APPLICATION FORM

NAME OF CHILD	NICKNAME
DATE OF BIRTH	HEALTH CARD NUMBER

PARENT/LEGAL GUARDIAN INFORMATION

NAME		RELATIONSHIP
ADDRESS		
HOME PHONE	WORK PHONE	CELL PHONE
EMAIL ADDRESS		
NAME		RELATIONSHIP
ADDRESS		
HOME PHONE	WORK PHONE	CELL PHONE
EMAIL ADDRESS		

MOST RESPONSIBLE PHYSICIAN OR PRIMARY CARE PROVIDER

NAME	SPECIALTY
ADDRESS	
TELEPHONE	FAX

PHARMACY

NAME	
ADDRESS	
TELEPHONE	FAX

COMMUNITY RESOURCES

CCAC CASE MANAGER	TELEPHONE NUMBER
SOCIAL WORKER	TELEPHONE NUMBER
DIETICIAN	TELEPHONE NUMBER

SCHOOL

NAME OF SCHOOL	
TEACHER'S NAME	TELEPHONE NUMBER

FAMILY INFORMATION

WHO DOES YOUR CHILD LIVE WITH? (INCLUDING SIBLINGS AND AGES OF SIBLINGS)

MEDICAL INFORMATION

WHAT IS YOUR CHILD'S MEDICAL DIAGNOSIS AND MEDICAL CONDITION?
PLEASE PROVIDE PERTINENT HISTORY (PREVIOUS SURGERIES, PROCEDURES, OTHER ILLNESSES)
DOES YOUR CHILD HAVE ANY ALLERGIES? *If SO, PLEASE DESCRIBE ALLERGY TRIGGERS, REACTION, AND TREATMENT. PLEASE INDICATE IF THIS IS A SEVERE OR LIFE-THREATENING ALLERGY.*
ARE YOUR CHILD'S IMMUNIZATIONS UP TO DATE? *PLEASE PROVIDE A COPY OF YOUR CHILD'S IMMUNIZATION RECORD OR PROVIDE INFORMATION REGARDING ANY MISSING IMMUNIZATIONS.*

WHAT IS YOUR CHILDS CODE STATUS? *PLEASE SELECT WHICH BOX.*

☐ 1- **FULL CODE:** I request that in the event of a medical emergency, staff will secure all emergency medical treatment deemed necessary.

☐ 2- **DNR:** I have provided a Do Not Rescucitate/No CPR letter or medical directive, which outlines requested medical interventions in the event of a medical emergency.

WHAT IS YOUR CHILD'S CURRENT WEIGHT?

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS OR DEVICES? PLEASE SELECT ALL BOXES THAT APPLY. MORE INFORMATION WILL BE COLLECTED DURING INTAKE:

- ☐ **SEIZURE DISORDER**
- ☐ **BEHAVIORAL CARE NEEDS**
- ☐ **CENTRAL VENOUS ACCESS DEVICE- INCLUDING PICC LINE, IMPLANTED PORT (PORT-A-CATH, POWER PORT), TUNNELED (HICKMAN) LINE, OR OTHER CENTRAL LINE**
- ☐ **PERIPHERAL INTRAVENOUS THERAPY**
- ☐ **TRACHEOSTOMY**
- ☐ **OXYGEN THERAPY**
- ☐ **MECHANICAL VENTILATION, INCLUDING CPAP OR BIPAP**
- ☐ **G-TUBE, GJ-TUBE, OR NG TUBE FEEDING**
- ☐ **TOTAL PARENTERAL NUTRITION (TPN)**
- ☐ **OSTOMY**
- ☐ **INDWELLING OR INTERMITTENT URINARY CATHETERIZATION**
- ☐ **WOUND CARE OR SPECIALIZED SKIN CARE**
- ☐ **ROUTINE PERITONEAL OR HEMODIALYSIS**

WHAT ARE YOUR MAIN GOALS OF CARE FOR YOUR CHILD DURING THEIR STAY AT EMILY'S HOUSE?
PLEASE DESCRIBE BELOW

1.
2.
3.

HOW DOES YOUR CHILD COMMUNICATE?

WHAT ARE YOUR CHILD'S LIKES/INTERESTS?

RESPIRATORY

DOES YOUR CHILD HAVE ANY RESPIRATORY CONCERNS? *IF SO, PLEASE COMPLETE THE FOLLOWING:*

Baseline chest sounds (clear/congested/wet)**:** ____

Baseline O2 Saturation: _____

O2 Mode of delivery: ☐ Nasal prongs ☐ Face mask ☐ Trach mask ☐ Blow-by

Daytime: O2 concentration LPM: ________ ☐ Continuous ☐ When napping ☐ PRN

Nighttime: O2 concentration LPM: ________ ☐ Continuous ☐ When sleeping ☐ PRN

O2 Sat monitoring:

Frequency: ☐ Continuous ☐ Napping ☐ Overnight ☐ Spot Checks____________

O2 monitor alarm settings:

Suctioning:

Type(s): ☐Oral ☐ Nasal tip ☐ Nasal pharyngeal ☐ Deep Suction

Deep/Nasal pharyngeal: Size catheter_____ Depth of suctioning: _____

Instructions:

SEIZURES

DOES YOUR CHILD HAVE A HISTORY OF SEIZURES ? *IF SO, PLEASE DESCRIBE BELOW*

History of any known seizure activity: YES ☐ **NO** ☐

Last Seizure and Type:

Type(s)/Description of Seizures:

Frequency and Duration:

Interventions:

Emergency Protocol:

PAIN MANAGEMENT

DOES YOUR CHILD HAVE A HISTORY OF PAIN? *IF SO, PLEASE DESCRIBE*
WHAT MEDICATIONS DOES YOUR CHILD USE TO TREAT PAIN?
WHAT OTHER THERAPIES DOES YOUR CHILD USE TO TREAT PAIN? *EXAMPLES INCLUDE HEAT/COLD APPLICATION, MASSAGE, GUIDED IMAGERY, DISTRACTION, ETC.*
DOES YOUR CHILD USE A PAIN SCALE TO DESCRIBE HIS/HER PAIN? *IF SO, PLEASE INDICATE WHICH SCALE, AND HOW IT IS USED*

DIETARY INFORMATION

IS YOUR CHILD FED ORALLY? *IF NO, PLEASE SCROLL DOWN TO "ENTRAL FEEDING"*
IF YES, WHAT TYPE OF DIET IS REQUIRED? *PLEASE SELECT ALL THAT APPLY* ☐ **REGULAR DIET** ☐ **SOFT DIET** ☐ **PUREED FOODS** ☐ **VEGETARIAN/VEGAN-** *PLEASE DESCRIBE RESTRICTIONS BELOW* ☐ **KOSHER-** *PLEASE DESCRIBE RESTRICTIONS BELOW* ☐ **HALAL-** *PLEASE DESCRIBE RESTRICTIONS BELOW* ☐ **OTHER (PLEASE DESCRIBE):**
PLEASE LIST ANY DIETARY RESTRICTIONS, INCLUDING FOOD ALLERGIES, DISLIKES, AND ADDITIONAL INFORMATION ON SPECIAL DIET, IF SELECTED ABOVE
PLEASE LIST SOME OF YOUR CHILD'S FAVOURITE FOODS

PLEASE DESCRIBE ANY FEEDING ROUTINES YOUR CHILD HAS AT HOME, INCLUDING FEEDING STRATEGIES, MEAL AND SNACK TIMES, ETC.

DOES YOUR CHILD REQUIRE ASSISTANCE WITH FEEDING? *IF SO, PLEASE DESCRIBE*

IS YOUR CHILD FED THROUGH ENTRAL FEEDING? *IF SO, PLEASE COMPLETE THE FOLLOWING:*

☐ G-Tube Mickey ☐ G-Tube Catheter ☐ GJ-Tube ☐ NG-TUBE

Size: **Measurement:**______ cm

Feed Type/Recipe:

Feed Rate:

Feed Times:

Flushes:

Type of Water:

Volume: **Pre Meds:** **Post Meds:**

Pre-Feeds: **Post-Feeds:**

24-hour total flush volume: ☐ None ☐ Yes, ____________

Site Care:

Position for Feeding and Post Feeding:

Venting or Drainage:

Frequency of Bag Change: ☐ ☐ Other as per parent request, _______________

HYGEINE

DOES YOUR CHILD USUALLY HAVE A: ☐ **TUB BATH** ☐ **SHOWER** ☐ **SPONGE/BED BATH**	
HOW FREQUENTLY IS YOUR CHILD BATHED?	
WHAT TIME OF DAY IS YOUR CHILD BATHED?	
HOW OFTEN IS YOUR CHILD'S HAIR WASHED?	
HOW OFTEN ARE YOUR CHILD'S TEETH BRUSHED?	

TOILETING

DOES YOUR CHILD HAVE A TOILETING ROUTINE? *IF SO, PLEASE DESCRIBE THE USUAL ROUTINE*	
DOES YOUR CHILD REQUIRE DIAPERS? *IF SO PLEASE INDICATE TYPE AND SIZE*	
HOW OFTEN DOES YOUR CHILD USUALLY HAVE A BOWEL MOVEMENT?	
DOES YOUR CHILD HAVE A ROUTINE FOR CONSTIPATION? *IF SO, PLEASE DESCRIBE ROUTINE*	

MOBILITY

DOES YOUR CHILD MOVE INDEPENDENTLY? *IF NOT, PLEASE DESCRIBE ASSISTIVE DEVICES USED*
DESCRIBE ANY SPECIAL POSITIONING REQUIRED FOR YOUR CHILD, FOR SEATED AND LYING POSITIONS:
DOES YOUR CHILD REQUIRE DAILY RANGE OF MOVEMENT EXERCISES? *IF SO, PLEASE DESCRIBE HERE OR ATTACH EXERCISE INSTRUCTIONS TO APPLICATION*

SLEEP

DOES YOUR CHILD USUALLY SLEEP IN A: ☐ BED ☐ CRIB
PLEASE DESCRIBE YOUR CHILD'S BED TIME AND ROUTINE
PLEASE DESRIBE NAP TIME ROUTINES, IF YOUR CHILD NAPS
WHAT TIME DOES YOUR CHILD NORMALLY WAKE UP? IF YOUR CHILD WAKES UP AT NIGHT, HOW DO YOU SETTLE HIM/HER?

COUGH ASSIST

Times:

Inhalation Pressure:

Exhalation Pressure:

Cycles:

Sets:

Special Instructions:

BIPAP

Reason for BiPap:

Schedule:

Type of water for humidification system:

Special Instructions:

02 Saturation Monitor overnight:

Mode:

Resp. Rate:

High Pressure:

Low Pressure:

TRACHEOSTOMY

Trach dependent: Yes ☐ No ☐

Types: **Size:**

Daily Stoma Care:

Trach Ties Change Frequency:

Trach Change:

Frequency:

Change Process:

Tube Cleaning Instructions:

Humidification:

Day: While awake: **While napping:**

Night:

HME Care:

Speaking Valve:

CENTRAL VENOUS ACCESS DEVICE CARE

Type: ☐ PICC ☐ Implanted Port (type & size:) ☐ Tunnelled Central Catheter (Hickman)

How Many Lumens:

Lumen uses:

Type of Caps: **Frequency of Change:**

Type of Dressing:

Frequency of Dressing Change:

Special Care Instructions:

MEDICATIONS- *PLEASE LIST CURRENT MEDICATIONS IN CHART BELOW, OR PROVIDE US WITH A COPY OF YOUR CHILD'S PRESCRIPTIONS AND MEDICATION TIMES/ROUTINE*

MEDICATION NAME AND CONCENTRATION	DOSE	ROUTE	TIME(S) GIVEN	REASON GIVEN