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		

EMERGENCY CONTACT OR ALTERNATE DECISION MAKER

NAME		RELATIONSHIP
ADDRESS		
HOME PHONE	WORK PHONE	CELL PHONE
EMAIL ADDRESS		

FOR ADMINISTRATIVE PURPOSES: ☐ SR ☐ PSM ☐ TTH ☐ EOL

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)
PLEASE LIST ANY OTHER INDIVIDUALS OR FAMILY MEMBERS WHO ARE INVOLVED IN CARE *IF YOU WOULD LIKE TO ALLOW VISITORS OTHER THAN THE IMMEDIATE FAMILY, PLEASE FILL OUT OUR VISITOR LIST ON ADMISSION*

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.*

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**

PLEASE DESCRIBE ANY OTHER SPECIALIZED MEDICAL CARE OR CONCERNS: *PLEASE INCLUDE ANY SENSORY IMPAIRMENTS SUCH AS HEARING OR VISUAL IMPAIRMENTS, AND IF ANY INTERVENTIONS ARE USED*

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

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*

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

DAILY CARE ROUTINES

FAVOURITE ACTIVITIES

PLEASE TELL US A LITTLE BIT ABOUT YOUR CHILD, AND HIS/HER INTERESTS:
FAVOURITE COLOUR?
FAVOURITE MOVIES/TV SHOWS?
FAVOURITE BOOKS?
FAVOURITE ACTIVITIES/TOYS?
FAVOURITE MUSIC?
WHAT MAKES YOUR CHILD HAPPY?

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*

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*	

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?	

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?

DIETARY INFORMATION

IS YOUR CHILD FED ORALLY? *IF NO, PLEASE DESCRIBE HOW YOUR CHILD IS FED*
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*