

# Respite Intake Form

Date:

<b>FAMILY/CLIENT INFORMATION</b>			
Name – Client (Last, First, MI)		Birth date (mm/dd/yyyy)	
Name – Primary Caregiver (Last, First, MI)		Nickname (if any)	
Home Address (Street, City, State, Zip)		Phone (Home)	Work Phone:
Name - Emergency Contact		Emergency Contact Phone #1:	
Emergency Contact Address (Street, City, State, Zip)			
<b>HEALTH CARE</b>			
Local Primary Physician (Name)		Phone:	
Specialty Physician (Name, specialty)		Phone:	
Specialty Physician (Name, specialty)		Phone:	
Hospital Preference		Pharmacy (Name, phone):	
Allergies (list):		Type of reaction:	
<b>MEDICATIONS</b>			
NAME OF MEDICATION	Dose	Route	Time
1.			
2.			
3.			
<b>MEDICAL DIAGNOSIS (list):</b>			
1.			
2.			
3.			
<b>Cognitive Ability</b>			
<input type="checkbox"/> Normal Functioning <input type="checkbox"/> Developmental Delay (Circle one):    Mild    Moderate    Severe    Developmental Age:			
<b>NUTRITION:</b>			
Diet: <input type="checkbox"/> Regular <input type="checkbox"/> Special (describe):			
Feeds Self <input type="checkbox"/> No <input type="checkbox"/> Yes    If "Yes", uses: <input type="checkbox"/> Spoon <input type="checkbox"/> Fork <input type="checkbox"/> Hands			
Special Feeding Concerns (aspiration, tube fed, problems with textures, etc) <input type="checkbox"/> No <input type="checkbox"/> Yes (specify):			
Favorite Foods:			
Refused Foods:			
<b>Mobility Issues:</b>			
<input type="checkbox"/> Independent <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> 1 Person Assist <input type="checkbox"/> 2 Person Assist <input type="checkbox"/> Bedbound <input type="checkbox"/> Braces <input type="checkbox"/> Cane <input type="checkbox"/> Prosthesis <input type="checkbox"/> Splints <input type="checkbox"/> Other (describe):			

## SLEEP

Current Sleep Schedule:

Sleep Preferences:

## DIAPERING & TOILETING

Independent in toileting?  No  Yes

Bladder Control  Always  Sometimes  Incontinent  Remind  Schedule

Bowel Control:  Always  Sometimes  Incontinent  Remind  Schedule

Toileting Instructions:

## Personal Hygiene / Dressing

Shower/Bath  Independent  Some assistance  Total Assist

Washing face/Hands  Independent  Some assistance  Total Assist

Brushing Teeth  Independent  Some assistance  Total Assist

Dressing/Undressing  Independent  Some Assistance  Total Assist

Special Instructions:

## COMMUNICATION

Family speaks what language?

English  Spanish  Hmong  Other (specify):

Does client use sign language?

No  Yes

Other forms of communication – Describe:

Client Speaks in:

Words  Sentences

## SELF-EXPRESSION & COMFORTING

How would you describe the client's temperament and personality?

What causes the client to feel angry or frustrated?

What does the client enjoy doing?

What does the client do well?

How does the client get along with children, adults and pets?

How does the client communicate his/her needs ( when hungry, tired, etc.)?

What frightens the client and how is it shown?

How does the client express feelings of happiness, enjoyment, etc.?

Client likes to be:

Held  Sung to  Rocked  Read to  Other (specify):

Special things you say or do to comfort the client:

Does the client have a special object (pacifier, blanket, stuffed animal, etc.) from home that would help ease the transition to respite care? – (Specify)

Does the client require special discipline techniques (please describe):