

The Caregiver ReCharge service is in-home relief for the Primary caregiver who is experiencing high levels of stress. For more information or assistance completing this form, contact 905-281-4443.

Referral Source Information			
Referral Source's first name:		Referral Source's last name:	
Referral Source's organization/agency:		Referral Source's phone number:	ext.
Date of referral: (dd/mm/yyyy)		Consent for referral obtained?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Caregiver Stress Indicator(s):	<input type="checkbox"/> Verbal Disclosure <input type="checkbox"/> Personal Observation <input type="checkbox"/> Formal Assessment – Specify Type:		
Reason for referral (briefly summarize situation):			

Primary Caregiver Information			
Caregiver's first name:		Caregiver's last name:	
Caregiver's home phone #:		Caregiver's alternate phone #:	<input type="checkbox"/> Cell: <input type="checkbox"/> Work:
Caregiver's e-mail address:		Does the caregiver authorize being added to our mailing list to receive future caregiver information:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Caregiver's date of birth: (dd/mm/yyyy)		Relationship to care recipient:	
Caregiver's Ontario health card number (+version):			
Does the caregiver require translation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which language?	
Does the caregiver live with the care recipient?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, caregiver's address:	Address: Unit: City: Prov.: Postal Code:
Does the caregiver have any health issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify:	
How many individuals are being cared for by this caregiver?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4+	If more than 1, please specify caregiver's relationship to others:	
How many caregiving hours does the Caregiver provide to the care recipient?		Daily hrs:	Weekly hrs:
Type of caregiving activities provided by the caregiver:	<input type="checkbox"/> Personal Hygiene/Bathing <input type="checkbox"/> Toileting <input type="checkbox"/> Transferring <input type="checkbox"/> Dressing/Undressing <input type="checkbox"/> Meal Preparation / Assistance with Eating <input type="checkbox"/> Medication Assistance / Reminders <input type="checkbox"/> Exercises / Range of Motion <input type="checkbox"/> Light Housekeeping / Laundry / Groceries <input type="checkbox"/> Companionship/Friendly Visiting <input type="checkbox"/> Safety / Risk Monitoring <input type="checkbox"/> Other:		
Is there another (secondary) informal caregiver supporting the care recipient?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify relationship to primary caregiver and to care recipient:	
How many caregiving hours does the secondary/alternate caregiver provide to the care recipient?		Daily hrs:	Weekly hrs:
Does the caregiver have	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify relationship to	

someone other than the referral source assisting them to obtain respite support?		primary caregiver:	
If yes, phone number for this person		If yes, describe how this person assists/supports the caregiver (i.e. making calls, driving etc.)?	

Care Recipient Information			
Care recipient's first name:		Care recipient's last name:	
Is the care recipient's home the location for in-home respite?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Care recipient's address:	Address: Unit: City: Prov.: Postal Code:
Care recipient's date of birth: (dd/mm/yyyy)		Care recipient's gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Ontario health card number (+version):			
Does the care recipient require translation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which language?	
Type of caregiving to be provided during in-home respite service:	<input type="checkbox"/> Personal Hygiene/Bathing <input type="checkbox"/> Toileting <input type="checkbox"/> Transferring <input type="checkbox"/> Dressing/Undressing <input type="checkbox"/> Meal Preparation / Assistance with Eating <input type="checkbox"/> Medication Assistance / Reminders <input type="checkbox"/> Exercises / Range of Motion <input type="checkbox"/> Light Housekeeping / Laundry / Groceries <input type="checkbox"/> Companionship/Friendly Visiting <input type="checkbox"/> Safety / Risk Monitoring		
Does the care recipient have an infectious disease(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, type of infectious condition & precautions required:	
List the medical conditions / diagnosis of care recipient:			
List any behavioural issues present:			

Care Recipient Assessment Information			
Date of care recipient's most recent RAI assessment (if applicable): (dd/mm/yy)		Assessment conducted by: (name of organization)	
Consent given to share assessment:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Assessment attached? Assessment on IAR?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Type of RAI Assessment	<input type="checkbox"/> interRAI CHA <input type="checkbox"/> RAI-HC <input type="checkbox"/> RAI-PC		
RAI Assessment Outcomes Scores:	MAPLe:	CHESS:	ADL: IADL: CPS : DRS :

Fax: (905) 337-0770 or Phone: (905) 281-4443

Website: centralregistry.ca

Direct Email: respitereferrals@nucleusonline.ca

