



SNS RESPITE REPORT

Person/Persons to receive care _____

We understand the respite service period date(s) is/are to begin on _____
(Date)

at _____, ending on _____ at _____
(Time) (Date) (Time)

Sibling care: yes _____ no _____

Sibling Name(s) _____

Address of Respite Site _____ Phone _____

We are going to _____ Phone _____

_____ Phone _____

IN CASE OF EMERGENCY, and you cannot reach me, please call:

Name _____ Relationship _____

Address _____ Phone _____

Physician _____ Phone _____

Hospital _____ Phone _____

CURRENT INFORMATION

Please discuss at beginning of respite and use the space below for any useful/pertinent information:

We have discussed:

- | | | |
|---|--|--|
| <input type="checkbox"/> Current Health | <input type="checkbox"/> What to do during respite | <input type="checkbox"/> Sleep and bedtime |
| <input type="checkbox"/> Meals | <input type="checkbox"/> Skills to work on | <input type="checkbox"/> Behavior plan |
| <input type="checkbox"/> Toileting Needs | <input type="checkbox"/> Diet restrictions/allergies | <input type="checkbox"/> Home safety Current |
| <input type="checkbox"/> Adaptive/Special Equipment | <input type="checkbox"/> Feeding Program | <input type="checkbox"/> Sibling information |
| <input type="checkbox"/> System of Communication | <input type="checkbox"/> Grooming/Hygiene | |

Medication to be given: Yes _____ No _____

I hereby give permission to administer the following medication:

_____ (Signature of parent/guardian)

Medication	Time/Dosage	Procedure	Actual Time Administered	Provider Initials

Side effects _____

The care provider for Catholic Social Services Special Needs Program and the parent/guardian have reviewed the consumer's information file, discussed any special concerns and had any questions answered to their satisfaction.

Signature of Direct Care Provider

Date

Signature of Parent/Guardian

Date

Case Notes: What did you do while working with the consumer, what goals were worked on?

How did the consumer respond?

