

Registration form

La maison de répit La Ressource

1. PARTICIPANT IDENTIFICATION

First name, Last name : _____		Gender : <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other	Date of birth YYYY/MM/DD : _____
Participant's address : _____			Code Postal : _____
No. Health insurance : _____	Expiration date : _____	Language : <input type="checkbox"/> French <input type="checkbox"/> English <input type="checkbox"/> Other, give details _____	
Diagnostic : <input type="checkbox"/> ID <input type="checkbox"/> ASD <input type="checkbox"/> Trisomy 21	Level : _____	Other, give details : _____	
<input type="checkbox"/> Verbal <input type="checkbox"/> Gestural <input type="checkbox"/> Pictogram <input type="checkbox"/> LSQ	Other means of communication, specify : _____		
The participant responds to his or her name : <input type="radio"/> Yes <input type="radio"/> No	The participant responds to simple instructions : <input type="radio"/> Yes <input type="radio"/> No	Other, specify : _____	

Paratransit	
User number : _____	Accompanied : <input type="radio"/> Yes <input type="radio"/> No _____

2. NAME AND CONTACT INFORMATION OF PERSON WHO CAN CONSENT TO CARE

First name, last name : _____	Telephone number : _____
Address : _____	Postal Code : _____
E-mail : _____	
Link with the participant : _____	2 nd Telephone number : _____

3. NAMES AND CONTACT INFORMATION OF PEOPLE TO CONTACT IN CASE OF EMERGENCY

First name, last name : _____	Telephone number : _____
Link: _____	2 nd Telephone number: _____

First name, last name : _____	Telephone number : _____
Link: _____	2 nd Telephone number : _____

Condition not accepted: Behavioral disorder, aggressiveness (hits, pushes, bites, scratches, violence towards others, running away, self-mutilation, throwing objects, insulin, enteral nutrition).

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4. IDENTIFICATION OF STAKEHOLDERS

First name, Last name : <input style="width: 95%;" type="text"/>	Telephone number : <input style="width: 95%;" type="text"/>	<input type="checkbox"/> SP <input type="checkbox"/> SW (social worker) Other, give details : <input style="width: 95%;" type="text"/>
<input type="checkbox"/> CRDITED <input type="checkbox"/> CLSC <input type="checkbox"/> Teacher	Other, give details : <input style="width: 95%;" type="text"/>	

First name, Last name : <input style="width: 95%;" type="text"/>	Telephone number : <input style="width: 95%;" type="text"/>	<input type="checkbox"/> YOUR <input type="checkbox"/> TS Other, give details : <input style="width: 95%;" type="text"/>
<input type="checkbox"/> CRDITED <input type="checkbox"/> CLSC <input type="checkbox"/> Teacher	Other, give details : <input style="width: 95%;" type="text"/>	

5. L'ÉTAT DE SANTÉ PHYSIQUE ET MENTALE

Diagnosis(s) having a significant impact on respite:	
Allergies :	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify : <input style="width: 95%;" type="text"/>
Temper tantrum:	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify : <input style="width: 95%;" type="text"/>
Anxiety :	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify : <input style="width: 95%;" type="text"/>
To bite :	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify : <input style="width: 95%;" type="text"/>
Pica :	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify : <input style="width: 95%;" type="text"/>
Cognitive state (problem with memory, orientation, understanding, etc.):	Specify : <input style="width: 95%;" type="text"/>
Asthmatic :	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify : <input style="width: 95%;" type="text"/>
Epileptic :	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify : <input style="width: 95%;" type="text"/>
Behavioral difficulties (seizures, suicidal thoughts, inappropriate sexual behavior, etc.):	Specify : <input style="width: 95%;" type="text"/>
Other health problem/special care:	Specify : <input style="width: 95%;" type="text"/>

Medication : <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, attach the pharmacological profile.
Self-medication : <input type="checkbox"/> Yes <input type="checkbox"/> No	Specify, if applicable : <input style="width: 95%;" type="text"/>

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Vision	<input type="checkbox"/> Normal <input type="checkbox"/> Vision problem	Specify :	<input style="width: 95%;" type="text"/>
Hearing	<input type="checkbox"/> Normal <input type="checkbox"/> Deafness	Specify :	<input style="width: 95%;" type="text"/>
Dentition	<input type="checkbox"/> Normal <input type="checkbox"/> Denture <input type="checkbox"/> Edentulous	Specify :	<input style="width: 95%;" type="text"/>

Nutrition-hydration (attach a protocol if applicable)			
Intolérance :	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify :	<input style="width: 95%;" type="text"/>
Dislikes :	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify :	<input style="width: 95%;" type="text"/>
Choking Hazard :	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify :	<input style="width: 95%;" type="text"/>
Special diet :	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify :	<input style="width: 95%;" type="text"/>
Food texture :	<input type="checkbox"/> Regular <input type="checkbox"/> Other	Specify :	<input style="width: 95%;" type="text"/>
Consistency of liquids:	<input type="checkbox"/> Regular <input type="checkbox"/> Other	Specify :	<input style="width: 95%;" type="text"/>
Need help with nutrition/hydration:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify :	<input style="width: 95%;" type="text"/>

Mobility assistance			
Orthotics :	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify :	<input style="width: 95%;" type="text"/>
Prosthesis :	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify :	<input style="width: 95%;" type="text"/>
Transfers :	<input type="checkbox"/> Bed <input type="checkbox"/> Toilet <input type="checkbox"/> Bath	Specify :	<input style="width: 95%;" type="text"/>
Walk :	<input type="checkbox"/> Walk outside <input type="checkbox"/> Walk inside	Specify :	<input style="width: 95%;" type="text"/>
Stairs :	<input type="checkbox"/> Staircase outside <input type="checkbox"/> Staircase inside	Specify :	<input style="width: 95%;" type="text"/>
Technical aids :	<input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair	Specify :	<input style="width: 95%;" type="text"/>

Life routine	
Rising in the morning :	<input style="width: 95%;" type="text"/>
Breakfast :	<input style="width: 95%;" type="text"/>
Morning occupation :	<input style="width: 95%;" type="text"/>
Supper :	<input style="width: 95%;" type="text"/>
Evening occupation :	<input style="width: 95%;" type="text"/>
Going to bed :	<input style="width: 95%;" type="text"/>
Night	<input style="width: 95%;" type="text"/>
Weekend	<input style="width: 95%;" type="text"/>

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Other activities of daily living (specify only if associated problem)			
Clothing :	Help required : <input type="radio"/> Yes <input type="radio"/> No	Specify :	
Hygiene :	Help required : <input type="radio"/> Yes <input type="radio"/> No	Specify :	
Shower :	Help required : <input type="radio"/> Yes <input type="radio"/> No	Specify :	
Hand washing	Help required : <input type="radio"/> Yes <input type="radio"/> No	Specify :	
Disposal:	Help required : <input type="radio"/> Yes <input type="radio"/> No	Specify :	
	<input type="checkbox"/> Diaper <input type="checkbox"/> Incontinence briefs	<input type="checkbox"/> Day <input type="checkbox"/> Night	Specify : <input style="width: 100%;" type="text"/>

The participant is able			
Do gross motor activities :	<input type="radio"/> Yes <input type="radio"/> No	Specify :	
Do fine motor activities :	<input type="radio"/> Yes <input type="radio"/> No	Specify :	
Do activities at the cognitive level :	<input type="radio"/> Yes <input type="radio"/> No	Specify :	
Do free activities :	<input type="radio"/> Yes <input type="radio"/> No	Specify :	
Walk more than an hour :	<input type="radio"/> Yes <input type="radio"/> No	Specify :	
Run or jump :	<input type="radio"/> Yes <input type="radio"/> No	Specify :	
Maintain attention :	<input type="radio"/> Yes <input type="radio"/> No	Specify :	
Use a tablet, computer, etc. :	<input type="radio"/> Yes <input type="radio"/> No	Specify :	

Further information :

Completed by:

Signature

By signing this form, you agree that La Maison Répit La Ressource will use this information while keeping it strictly confidential.

Date

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