Southern Health Santé Sud

RESPITE CARE IN A RESPITE BED
PHYSICIAN'S NOTIFICATION AND STANDING ORDERS

The respite care program provides short term admission for intermittent periods of relief for family members who care for a dependent person in their own home in the community. To ensure proper care of the respite client, we require the following medical information by (date): _____

Please fax this completed form to (facility): _____ **Fax #:** _____

Client Name:	
PHIN:	**Telephone No:**
Address:	
Scheduled respite admission– enter dates - from:	**to:**
Diagnosis:	
Current Medication:	
Individuals admitted for respite shall be placed on medications they are currently taking at home unless otherwise requested by you.	
Diet Orders:	
Known Allergies:	
Health Care Directive: ☐ No ☐ Yes If yes, attach copy	**Advance Care Plan Level:**
Other:	
Please complete & attach Standing Order Sheet	
Physician Name:	
Physician Signature:	**Date:**