ADDRESSOGRAPH

SUPPLEMENTAL STAFFING, EQUIPMENT & SUPPLIES REQUEST FORM

New Request: ☐ Yes ☐ No **Increase:** ☐ Yes ☐ No **Time required:**

Reason for Request:

Requested by: ______________________ **Date of Request:** _____________________

Resources Required		
Staffing	Required Classification:	Rate of Pay:
	Estimated # of hours/day:	Estimated # of days/week:
Equipment	Type:	Estimated monthly cost:
Supplies	Type:	Estimated monthly cost:

Check all Alternative Interventions Tried			
☐ Interdisciplinary Case Conference	☐ Companion Care ☐ Volunteer ☐ Paid	☐ Geriatric Psychiatrist	☐ Geriatrician
☐ Social Worker	☐ Dietitian	☐ Meeting with resident	☐ Family involvement
☐ OT	☐ Increased supervision	☐ Behaviour mapping	☐ Behaviour management
☐ Physical assessment	☐ Medication review	☐ Treatment changes	☐ Seniors Consultation Team
☐ Lab work	☐ Spiritual support	☐ Social/Emotional support	☐ PIECES
☐ Room change	☐ Transfer to other unit	☐ Transfer to other facility	☐ Other

Review Dates: _____________________ _____________________ _____________________

_____________________ _____________________ _____________________

Director of Health Services:	Date Received: ______________ Approved: ☐ Denied: ☐ Forwarded to Appropriate Executive Director: _________________
Executive Director:	Date Received: ______________ West: ☐ East: ☐ North ☐ Mid ☐