CHILDREN'S CENTER
AT THE PHOENIX

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Pediatric Respite Admission Packet

Thank you for your interest in our Pediatric Respite Program at Children's Center at The Phoenix. The following information is required for every respite admission.

Required Information:

- ☐ Please complete the attached packet of information.
- ☐ Please include a copy of the front and back of the insurance card
- ☐ Please contact the patient's primary care physician to provide the following:
  - Most recent physical exam (must be within the year)
  - Immunization record (please include current flu vaccine and COVID-19 vaccines/boosters if applicable)
  - Current medication list
- ☐ If patient attends school or day program, please provide a copy of the current IEP.

This information may be returned to us by dropping it off at the facility front desk, or you may send it via email or fax (see below). If you have any questions or concerns, please don't hesitate to contact me.

Sincerely,

Alexandra DeLuise

Alexandra DeLuise
Office Phone: (973) 839-2119 x137
Cell Phone: (908) 907-7136
E-Fax: (973) 839-3007

Patient Name: _____ Date: _____

Pediatric Respite Admission Packet

Section 1 - Demographics

Patient Name: _____ DOB: _____

SSN: _____ Sex: ☐ Male ☐ Female

Patient Address: _____

Application Completed by: _____ Relationship: _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

Email: _____ Work Phone: _____

Insurance Information (please provide copy of front and back of card):

Insurance Name: _____ Policy Number: _____

Group Number: _____ Ins. Address: _____

_____ Policy Holder Name: _____

DOB: _____ SSN: _____

Relationship: _____ Employer: _____

Employer Address: _____

Medicaid? ☐ No ☐ Yes County: _____ Medicaid Number: _____

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

Email: _____ Work Phone: _____

X_____ Date: _____

Signature of responsible party

Patient Name: _____ Date: _____

Section 2 – General Medical Information

1. What is your child's DNR status? Select only one

FULL CODE DNR

2. What is your child's height? _____ weight? _____

3. Please list any allergies: _____

4. If your child has or has had any of the following, please check it below:

- ☐ Seizure Disorder
- ☐ Vision impairment
- ☐ Learning disability
- ☐ Hearing impairment
- ☐ Shunt
- ☐ Asthma/BPD
- ☐ Heart defect
- ☐ Osteoporosis
- ☐ History of Fractures: _____
- ☐ Skin breakdown: _____
- ☐ Psychiatric disorder: _____
- ☐ Artificial airway: _____

Section 3- Behavioral

1. Does your child exhibit any of the following behaviors? Please check all that apply and list how you manage these behaviors.

- ☐ Self-abuse _____
- ☐ Wandering _____
- ☐ Sensitive to touch _____
- ☐ Abusive toward others (hitting/biting) _____
- ☐ Self-stimulating behaviors (rocking/twirling) _____
- ☐ Emotional outbursts_____
- ☐ Other _____

_____

Section 4 – Rehab/Activities of Daily Living

1. Does your child require assistance with transfers?

- ☐ No
- ☐ Yes (circle one)

Mechanical Lift Two-Person Lift Stand-Pivot Transfer
One-Person Lift Slide Board Transfer Other: _____

Patient Name: _____ Date: _____

2. Does your child use a wheelchair?

- ☐ No
- ☐ Yes (please specify below)
  - Type of Chair (circle one):
    - Manual wheelchair
    - Power Wheelchair
  - What level of assistance does your child need with the wheelchair? (Circle one)
    - Independent Supervision
    - Verbal Cues
    - Dependent
    - Minimum assistance
    - Moderate Assistance
    - Maximum assistance

3. Does your child ambulate?

- ☐ No
- ☐ Yes (please specify below)
  - Does your child use an assistive device to walk?
    - ☐ No
    - ☐ Yes (please specify below): _____
  - What level of assist does your child need with walking? (Circle one)
    - Independent Supervision
    - Verbal Cues
    - Dependent
    - Minimum Assistance
    - Moderate Assistance
    - Maximum Assistance

4. Does your child use any medical equipment?

- ☐ No
- ☐ Yes (Please check all applicable below):
  - ☐ Ventilator
  - ☐ Tracheostomy → Type: _____ Size: _____
  - ☐ BiPAP/CPAP → Type of Interface? (Please circle one below):

A. Nasal Mask B. Nasal Pillow C. Full Face Mask

- ☐ Cough Assist
- ☐ Oxygen
- ☐ Chest Vest

Settings: _____

Frequency: _____

Patient Name: _____ Date: _____

Times of use: _____

5. Does your child use the toilet?

- ☐ No
- ☐ Yes (please specify below)
    - Does your child need supervision on the toilet? (Circle one)
        - Yes No
    - How Does your child indicate they need to use the toilet?
      _____

6. Does your child wear diapers?

- ☐ No
- ☐ Yes (please specify below)
    - When? (Circle one): Day Night Both

7. Females: If menstruating, what assistance is needed?

_____

8. Does your child dress independently?

- ☐ Yes
- ☐ No. What assistance is needed? _____

9. Does your child shower and wash self?

- ☐ Yes
- ☐ No.
    - What assistance/equipment is needed?
      _____

10. What are your child's usual sleeping hours? _____

11. Does your child use any orthopedic appliances/equipment?

- ☐ No
- ☐ Yes (Please specify below):
    - ☐ Leg braces: Left Right Both
      Schedule: _____
    - ☐ Hand splints: Left Right Both
      Schedule: _____
    - ☐ Trunk
      Schedule: _____
    - ☐ Helmet

Patient Name: _____ Date: _____

Schedule: _____

- ☐ Other Schedule: _____

12. Does your child communicate verbally?

- ☐ No
- ☐ Yes

13. Does your child use a communication device?

- ☐ No
- ☐ Yes (Please specify): _____
  - ☐ Will device be used while at Phoenix? Yes No
  - ☐ Any instructions for use of device?

    _____

    _____

14. How else does your child make their needs known? _____

_____

Section 5 – Nutrition 1.

1. Does your child have any food allergies or intolerances?

- ☐ No
- ☐ Yes (please specify): _____

2. Does your child have a feeding tube?

- ☐ No
- ☐ Yes (please specify)
  - Type of feeding tube: _____
  - Formula name: _____
  - Total volume of formula fed per 24 hours: _____

Select the method of tube feeding administration below and then list the details

- ☐ **Pump**: Run at _____ ml/hr until _____ ml is fed _____ times per day.
  Water flushes (amount and frequency): _____
  Timing of usual feeds: _____
- ☐ **Gravity Bag**: Feed _____ml in gravity bag _____ times per day.
  Water flushes (amount and frequency): _____
  Timing of usual feeds: _____
- ☐ **Bolus (by syringe):** Feed _____ml by bolus _____ times per day.
  Water flushes (amount and frequency): _____
  Timing of usual feeds: _____

Patient Name: _____ Date: _____

3. Does your child eat by mouth?

- ☐ No
- ☐ Yes (continue to answer below questions)
  - Are there any dietary restrictions?
    - ☐ Low Sodium
    - ☐ Consistent Carbohydrate
    - ☐ Other: _____
  - What consistency liquids does your child drink? (Check only one)
    - ☐ Regular Nectar
    - ☐ Mildly Thick
    - ☐ Honey/Moderately Thick
  - What consistency food does your child eat? (Check only one)
    - ☐ Regular – No modifications to foods. All foods are allowed.
    - ☐ Mechanical Soft – Meats are chopped into ½" pieces. Hard or sticky foods are not allowed (including crust on sandwiches). Fruits and vegetables are soft. Mixed consistencies are not allowed.
    - ☐ Ground – all foods are ground or pureed. Meats are ground with sauce/gravy. Vegetables are ground. Fruits/soups, and bread products are pureed.
    - ☐ Puree – all foods are pureed.

  - What assistance does your child need during meals? (Circle one)
    - ☐ Independently sets up and feeds self
    - ☐ Needs help with set up (cutting, opening)
    - ☐ Needs cues to eat meal, self-feeding but may need to be fed to complete meal
    - ☐ Needs to be fed a full meal

4. Does your child take an oral nutritional supplement (ie. pediasure, ensure, ensure plus)?

- ☐ No
- ☐ Yes (please explain):

  _____

  _____

Section 6 – Other

1. In the space below, please provide any additional information about your child: