Respite Registration

Horizons Behaviour Consulting
Ottawa, Ontario
(613) 601-3911

Thank you for your interest in receiving respite services from Horizons Behaviour Consulting!

Respite is an opportunity to leave your child in our care for a short duration so that you may complete an activity that you would be otherwise unable to in the presence of your child or if you just need a few moments for self-care. The respite team will be providing play-based activities with the potential facilitation for some social play. Please note that this is not a substitute for behavioral intervention or skill development. If you are interested in behavioral intervention for your child feel free to reach out using the contact information below.

Filling out this registration form provides us with all the information needed to start respite services.

Please thoroughly fill out each page of the registration form that is provided below. Once you have completed the forms, please email me at info@horizonsbehaviourconsulting.com and I will be in contact with you when I receive the registration form to continue the intake process. If you have any questions along the way, please do not hesitate to contact me. We look forward to working with you and your family!

Sincerely,

Matt Derkach, M.ADS, BCBA
Clinical Director
Horizons Behaviour Consulting
Contact: 613-820-1919
www.horizonsehaviourconsulting.com

Respite Registration

Horizons Behaviour Consulting
Ottawa, Ontario
(613) 601-3911

Person completing this form

Name: _____
Please indicate relationship to the child: ☐ Parent ☐ Guardian ☐ Other: _____

Are you authorized to consent for this individual's healthcare?
☐ No ☐ Yes

Child's personal information:

Legal Name		**Preferred Name**	
Gender	☐ M ☐ F ☐ Other	**Date of Birth**	
Home Address			

Family Information

Child lives with: _____

Parent/Guardian 1

Legal Name		**Preferred Name**	
Relationship	☐ Mother ☐ Father ☐ Other; please specifiy _____		
Home Address			
Cell phone		**Home Phone**	
Email			
Employed by			
Occupation			

Parent/Guardian 2

Legal Name		**Preferred Name**	
Relationship	☐ Mother ☐ Father ☐ Other; please specifiy _____		
Home Address			
Cell phone		**Home Phone**	
Email			
Employed by			
Occupation			

Primary language of child: ☐ English ☐ Other: specify _____

Percent of time the child is exposed to non-English language(s):_____

Horizons Behaviour Consulting
Ottawa, Ontario
(613) 601-3911

Emergency Contact Information

Please provide the name and phone number of an individual who can be called in case of an emergency when parents/guardians are not available.

Emergency Contact: _____

Relationship: _____

Home Phone Number: _____

Cell Phone Number: _____

Previous/Additional Service Providers

Has the child ever been assessed/evaluated by an Occupational Therapist, ABA Therapist, Speech and Language Therapist, Psychiatrist, Psychologist, Special Educator, or other mental health counselors? ☐ No ☐ Yes ☐ Unknown

If yes, please provide the following information:

Name		**Type of Specialist**	
Date service started		**Date service ended**	
Hours per week		**Length per session**	
Purpose of service			

Name		**Type of Specialist**	
Date service started		**Date service ended**	
Hours per week		**Length per session**	
Purpose of service			

Name		**Type of Specialist**	
Date service started		**Date service ended**	
Hours per week		**Length per session**	
Purpose of service			

Horizons Behaviour Consulting
Ottawa, Ontario
(613) 601-3911

Medical Information

Hospital/Clinic Preference:_____

Child's Primary Doctor: _____

Doctor Phone Number: _____

Diagnoses		
Allergies	☐ Yes ☐ No	If yes, please specify:
Medications	☐ Yes ☐ No	If yes, please specify:
Dietary Needs	☐ Yes ☐ No	If yes, please specify:
Other restrictions we need to know about	☐ Yes ☐ No	If yes, please specify:

**An additional *Permission to Administer Medication* form will need to be completed and on file for each specific medication your child takes at Horizons Behaviour Consulting.

Child's Interests

Three preferences (favorite activities, food, topics, toys, sensory)	**Three dislikes (things your child avoids or will not interact with**
1	1
2	2
3	3
Other important information regarding interests	

Horizons Behaviour Consulting
Ottawa, Ontario
(613) 601-3911

Other Considerations

Please describe below important cultural practices, rituals, traditions or beliefs that you believe are important for us to be aware of prior to beginning services.

Please answer the following questionnaire to the best of your ability

Does the child engage in any of the following behaviours, if yes please specify	☐ Hitting ☐ Biting ☐ Tantrums ☐ Breaking objects ☐ Self-injurious behaviour ☐ Head banging ☐ Undressing in public ☐ Other _____	Comments:
If the chid engages in any of the previous behaviours, how often do they occur?	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	
Is the child toilet trained	☐ Yes ☐ No	
How well is the child able to follow vocal instructions?	☐ Able to follow two or more step instructions and only needs to be asked once. ☐ Able to follow one step instructions and only needs to be asked once. ☐ Needs assistance to follow instructions. ☐ When given an instruction they will engage in one of the behaviours from the first question (please specify)	
Does the child ever wander, leave a safe area, or caregiver without permission?	☐ Yes (please specify how often) _____ ☐ No	
Please select the options that best reflects the child's current speech abilities	☐ Able to communicate wants, needs, and maintain conversation in full clear sentences. ☐ Able to communicate needs in full sentences. ☐ Able to communicate needs with one or two words. ☐ Does not communicate using words	

Please indicate the level of support required for daily living skills (i.e. dressing, eating, brushing teeth)	☐ High level of support required ☐ Moderate level of support required ☐ No support required (indepdendent)	
Please select the skills that the child currently HAS:	☐ Shares toys with others. ☐ Plays with others. ☐ Asks for help. ☐ Asks for items/activities they want. ☐ Can imitate something after watching someone else do it.	☐ Can read words or sentences (specify) ☐ Can count up to: _____ ☐ Recognizes and identifies letters and numbers ☐ Recognizes and identifies common people or items

SIGNATURE and ACKNOWLEDGEMENT

By signing, I hereby certify that the above statements are true and correct to the best of my knowledge and understand all information in this packet will become part of the patient's clinical file.

_____ _____

Signature (Parent/Guardian) Date

Horizons Behaviour Consulting
Ottawa, Ontario
(613) 601-3911

CONSENT FOR COMMUNICATION

Horizons Behaviour Consulting would like to know your preferences by which we may contact you regarding your services.

I do not have a preference, Horizons Behaviour Consulting may contact me using either email or phone ____ No ____ Yes

I prefer the majority of all contact to take place via phone ____ No ____ Yes. If yes, please indicate below best contact number(s):

Home Number: _____ Best time(s) to call: _____

Is it ok to leave a message at this number? ____ No ____Yes

Work Number: _____ Best time(s) to call: _____
Is it ok to leave a message at this number? ____No ____ Yes

Cell Number: _____ Best time(s) to call: _____
Is it ok to leave a message at this number? ____No ____ Yes

I prefer the majority of all contact to take place via email ____No ____ Yes

If yes, please review and sign the consent for email below:

Staff working for Horizons Behaviour Consulting may communicate via email, but this agreement does not obligate staff at Horizons Behaviour Consulting to communicate via email. Email may be one of many forms of communication with staff at Horizons Behaviour Consulting.

Risk of using email

I want to use email to communicate to staff at Horizons Behaviour Consulting about my/the child's personal health care. I understand that staff will use reasonable means to protect the security and confidentiality of email information sent and received. I understand that there are known and unknown risks that may impact the privacy of my personal health care information when using email to communicate. I acknowledge that those risks include, but are not limited, to:

- Email can be forwarded, printed, and stored in numerous paper and electronic forms and be received by many intended and unintended recipients without my knowledge or agreement.
- Email may be sent to the wrong address by any sender or receiver.
- Email is easier to forge than handwritten or signed papers.

- Copies of email may exist after the sender or the receiver has deleted his or her copy.
- Email service providers have a right to archive and analyze emails sent through their systems.
- Email can be intercepted, altered, forwarded, or used without detection or authorization.
- Email can spread different computer viruses.
- Email delivery is not guaranteed.

Understanding the use of email, I give permission for staff at Horizons Behaviour Consulting to send me email messages that include my/the child's personal health care information and understand that my email messages may be included in my/the patient's medical record. I have read and understand the risks of using email as stated above and agree that email messages may include protected health information about me/the child, whenever necessary.

Email address:

_____

Child's name

_____

_____ _____

Signature (Parent/Guardian) Date

Please send Registration Form to info@horizonsbehaviourconsulting.com once completed