***Request for support***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Supported Person**  Normally, it's the person who needs support who makes the request, upon referral from a healthcare professional or other source. If they need help to complete the form, a healthcare professional, a relative, or a friend can do it for them. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Name :** (Mister, Madame, other): | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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|  | **First Name** | | | | | | | | | | |  | | **Maiden Name** (if applicable) | | | | | | | | | | | |  | | | | **Last Name** | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date of Birth:** | | | | |  | | | | | | | | | | | | | | YYYY-MM-DD | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Address:** | |  | | | | | | | | | | | | | | | | | | | | | | **Town:** | |  | | | | | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Province:** | | Québec | | | | | | | | | | | | **Postal code:** | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Home phone:** | | | | | | ( |  | | ) | |  | | | | - |  | | | | | **Cell phone:** | | | | | ( | | |  | | | | ) | |  | | - | |  | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Emergency contact person 1:** | | | | | | | | | | | | | |  | | | | | | | | | | | **Phone:** | ( | | |  | | | | ) | |  | | - | |  | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Emergency contact person 2:** | | | | | | | | | | | | | |  | | | | | | | | | | | **Phone:** | ( | | |  | | | | ) | |  | | - | |  | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Email address:** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Languages spoken:** | | | | | | | | | |  | | | **French** | | | | | | | | |  | **English** | | |  | | | | | **Spanish** | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Health information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Situation :** | | | | | | |  | **Critical Illness** | | | | | | | | |  | | | **Palliative care** | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Information :** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Signature of consent**  Consent signature of the supported person or their representative. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Signature:** | | | |  | | | | | | | | | | | | | | | | | | | | | **Date:** | |  | | | | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Relationship with the supported person** | | | | | | | | | | | | | | | | | |  | | | | | | | **Phone:** | | | ( | | | |  | | ) | |  | | - | |  | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Physician** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** (Mister, Madame, other): | | | | | | | | | |  | | | | | | | | | | | | | | | | | |  |
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|  | **First Name** | | | | | | |  | | **Maiden Name (if applicable)** | | | | | |  | | | **Last Name** | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Professional:** | | | |  | | **Physician** | | | | |  | | **Nurse** |  | **Social Worker** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Other:** | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Establishment:** | | | |  | | **Hospital** | | | | |  | | **Long-Term Care Hospital Center** | | | | | | | | | | |  | | **CLSC** | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Other:** | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Phone:** | | ( |  | | ) | |  | - |  | | | **Phone organization:** | | | ( | |  | | | ) |  | | - | |  | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Signature of the healthcare professional**  Signature of the referring healthcare professional (if applicable) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Signature:** | | |  | | | | | | | | | | | | | | | **Date:** | | | |  | | | | | | |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Support Requested**  Identify the location where the support will take place and the desired time frame. | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Location of support:** | | | |  | **Residence for senior** | |  | | **Long-Term Care Hospital Center** | | | | |  | **Hospital** | |  | **Home** | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Address:** | |  | | | | | | | | | | | **Room Number:** | | | | |  | |  |
|  | | | | | | | | | | | | | | | | | | | | |
| **Start date of the support:** | | | | |  | | |  | | | More info… | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | |
| **Time Frame preferred** | | | | | | | | | | | | | | | | | | | | |
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|  | **Monday** | | **Tuesday** | | | **Wednesday** | | | | **Thursday** | | **Friday** | | | | **Saturday** | | | **Sunday** | |
| **Morning** |  | |  | | |  | | | |  | |  | | | |  | | |  | |
| **Afternoon** |  | |  | | |  | | | |  | |  | | | |  | | |  | |
| **Night** |  | |  | | |  | | | |  | |  | | | |  | | |  | |
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***Agreement***

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Services** | | | | | | | | | | |
| Albatros is a movement whose actions must never go beyond what a parent (father or mother) feels is appropriate in certain circumstances, or what they would do for their child.  This service is provided based on the explicit request of the beneficiary, the family, or a significant other.  The healthcare staff remains the authority regarding the professional care and services to be provided.  Taking into consideration these premises:   * The administration of medication, at home, requires written authorization and the supported person must be able to take it on is own. * No manipulation aimed at moving the patient is permitted in the absence of the family. | | | | | | | | | | |
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| **Supported person (Beneficiary)** | | | | | | | | | | |
|  | | | | | | | | | | |
| **Name:** (Mister, Madame, other): | | | |  | | | | | |  |
|  | | | | | | | | | | |
|  |  | |  |  | | |  | |  |  |
|  | **First Name** | |  | **Maiden Name (if applicable)** | | |  | | **Last Name** |  |
|  | | | | | | | | | | |
| **Significant person's consent signature** | | | | | | | | | | |
|  | | | | | | | | | | |
| **Signed at:** | |  | | | | **Date :** | |  | |  |
|  | | | | | | | | | | |
| **Signature:** | |  | | | | | | | |  |
|  | | | | | | | | | | |
| **Relationship with the supported person:** | | | | |  | | | | |  |
|  | | | | | | | | | | |

**Volunteer Support Coordinator**

Albatros Gatineau - La Lièvre

873-455-9632

AlbatrosGatineauLL@gmail.com