MONTAGE
SUPPORT SERVICES

Respite Profile

Revised November 2024

Name:	Date:	Date of First Respite Visit:
	Month/ /Day /Year	*Month/ /Day /Year*
Name of person completing this form:		
Persons involved in development of Respite Profile:		

Personal Information:			
Name:			
Date of Birth:	*Month/ /Day /Year*	**Sex:** ☐ **Male** ☐ **Female**	
Eye Colour:		**Hair Colour:**	
Religion:		**Language(s):**	
Health Card #:		**Wheeltrans #:**	
# of COVID Vaccines		**Password:** **Web Password:**	

*** = Section is Mandatory**

*** Support considerations and protocols required for below areas of support:**			
Diagnosis:			
Allergies:			
Mobility:			
Seizures:		**Continence Needs:**	
Speech:		**Hearing:**	
Vision:		**Diet:**	
Additional supports (for example Elopement, use of helmet etc.).:			

Respite Plan:
Are you looking for ☐ **Emergency Respite** ☐ **Planned Respite**
If you're looking for planned respite, how often would you like respite support at Montage?

Family/Guardian Information:			
Are you a:	☐ **Parent**	☐ **Guardian**	
Primary Contact Information:		**Emergency Contact Information:**	
Name:		**Name:**	
Address:		**Address:**	
City/Province:		**City/Province:**	
Postal Code:		**Postal Code:**	
Telephone (Home):		**Telephone (Home):**	
Telephone (Cell):		**Telephone (Cell):**	
Telephone (Work):		**Telephone (Work):**	
Home Email:		**Home Email:**	
Work Email:		**Work Email:**	

Services Information:		
Are you eligible for Services in Ontario?	☐ **Yes** ☐ **No**	
Are you an adult over the age 18 and have a developmental disability?		☐ **Yes** ☐ **No**
Are you using other out of home Respite services:	☐ **Yes** ☐ **No**	**If yes, where?**
Do you receive ODSP?	☐ **Yes** ☐ **No**	
Do you receive Passport Funding?	☐ **Yes** ☐ **No**	
Do you have a Person-Directed Plan?	☐ **Yes** ☐ **No**	

Assessments that will provide us with information that will help us better support you. ***if Yes then give relevant details to support most effectively.***		
Application for Developmental Supports and Services and Supports Intensity Scale	☐ **Yes** ☐ **No**	Details:
Occupational Therapy	☐ **Yes** ☐ **No**	Details:
Speech and Language	☐ **Yes** ☐ **No**	Details:

Behaviour Therapy	☐ **Yes** ☐ **N o**	Details:
Other	☐ **Yes** ☐ **No**	Details:

Other Supports Involved (*physicians, psychiatrist, schools, programs*):			
General Practitioner		**Phone number:**	
Address:			
Neurologist:		**Phone number:**	
Address:			
Dentist:		**Phone number:**	
Address:			
Optometrist:		**Phone number:**	
Address:			
School/Day Program:		**Phone number:**	
Address:			
Other:		**Phone number:**	
Address:			
Other:		**Phone number:**	
Address:			

Medication Information:			
Medication Name	**Dosage**	**Frequency**	**Purpose**

Meaningful Day (please describe what a meaningful day would look like)

* = Section is Mandatory

* Protocols and Special Instructions:
Please specify the level of support and level of supervision needed in the following sections. Provide detailed information about what this support should look like to ensure we meet the individual's needs, preferences, and comfort level.
1. Medication Administration Process
2. Communication Style
3. Bathing
4. Teeth brushing / Oral Hygiene
5. Shaving and hair care
6. Dressing
7. Transferring
8. Elimination (washroom use)
9. Sleeping/positioning

10. Seating/positioning
11. Meals **Is there a choking risk? ☐ Yes ☐ No**
Meal Preparation and Preferences:
Meal Assistance/Support with eating:
12. Transportation
13. Personal Finances (to include where to store money, decision making on purchases)
14. Community Supports (level of support required in the community)

Emotional Supports			
Do you have a Behaviour Support Plan:	☐ **Yes** ☐ **No** **(if 'yes', please attach)**		
Name of Behaviour Therapist:		**Phone:**	
Agency of origin (if applicable)			
Address:			

After completing the document please save or scan to submit it to the email below. Please contact us if you have any questions.

respite@montagesupport.ca