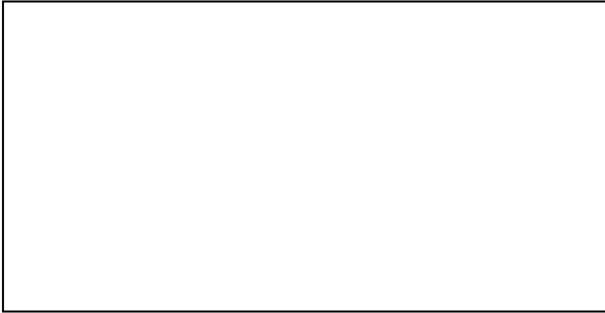
2725, Avenue du Mont-Royal est
Montréal (Québec) H1Y 0A1
Tel : 514-787-8801 Fax : 514-788-5854
Email : infirmiere@phare-lighthouse.com



APPLICATION FORM FOR ADMISSION

INFORMATION

Child's name :	Date of birth (YY/MM/DD):
Gender ☐ F ☐ M	Medic care number :
Allergies/intolerance (describe) :	Weight (Kg):
School:	Language spoken at home : ☐ Interpreter required
Country of birth :	Brothers/sisters : Name:___________________________ DOB:________________ Name:___________________________ DOB:________________ Name:___________________________ DOB:________________
Name / First name of mother (date of birth (year/month/day):	Name / First name of father (date of birth (year/month/day):
Address : Home phone number : (______)_______-__________________ Cell number : (______)_______-__________________ Work phone number : (______)_______-__________________ e-mail :	Address : Home phone number :(______)_______-__________________ Cell number : (______)_______-__________________ Work phone number : (______)_______-__________________ e-mail :

Means of communication used by the child (describe):

____
____

Affiliated CLSC:

Social worker : ____
Other professionals 1 : ____
Other professionals 2 : ____

What are the steps taken at your local CLSC ?

____
____
____
____
____
____
____
____
____
____

CARE AND TREATMENT

Respiration
☐ Tracheotomy
☐ Oxymetry
☐ Airway suctioning
☐ BPAP/CPAP
☐ Respirator
☐ O2
☐ Cough assist

Details :

Has had cardio respiratory resuscitation (CPR): ☐ Yes ☐No

Feeding
☐ Oral feeding
☐ NG tube
☐ Gastrostomy
Details:

Diet :

Mobility
☐ Walks
☐ Stroller
☐ Wheel chair
☐ Patient lift
Details :

Elimination
☐ Toilet trained
☐ Diapers
☐ Urinary catheterization
☐ Constipation
Details :

Vaccination
Is the child's vaccination is up to date?
☐ Yes ☐No

Epilepsy

☐ Diastat
☐ Magnet
☐ Anticonvulsivants

→Type of seizure : ______
→frequency : ______
→lenght : ______
→intervention : ______

MEDICAMENT :

Do you have a seizure's protocol?
☐ Yes ☐ No
If you answer yes to this question, please join the seizure's protocol or medical documentation.

Have you join the medication profile to your application form?
☐ Yes ☐ No

Name and phone number of your Pharmacy: ______

MENTAL HEALTH AND BEHAVIOR

Are you applying for a child with autism?
☐ Yes ☐ No

Are you applying for a child with behavioural problems
☐ Yes ☐ No
If you answer yes to this question please specify the problem :
Agression ☐ Agitation ☐ Anxiety ☐ Crisis ☐ Violence ☐ Other ☐

More details :

______
______
______

FAMILY STATUS

Please describe the family dynamic, family background, help at home and other existing respite.

The custodial parent / Legal guardian (include judgement if necessary):

Not applicable ☐ Mother ☐ Father ☐ Other ☐

Do you have an active file at the child protection service agency?

☐ Yes ☐ No

Do not hesitate to provide us with any relevant information that may help us to know better your child.

Service requested:

☐ **Maison André-Gratton**

☐ **Home respite (3h/a week depending on the volunteer's availability)**

☐ **Palliative care**

Please send documents to the liaison nurse at the Lighthouse by :
Fax : 514-788-5854

e-mail: admission@phare-lighthouse.com
mail at : The Lighthouse Children and Families
2725, avenue du Mont-Royal est
Montréal (Québec) H1Y 0A1

- A signed consent from parents giving us the authorization to obtain a summary of the child's medical file.
- Any documents that can help us evaluate the child's health or care required.
- This form filled and signed.

Referred by : ______________________________

Title and institution : ______________________________

Telephone : ______________________________

E-mail : ______________________________

Signature: ______________________________

Reception date of the request : ______________________________

Name:

Date of birth:

PART TO BE FILLED BY ATTENDING PHYSICIAN AND TEAM

Main diagnosis :

Other diagnosis :

Complication :

Medical summary and hospitalizations:

Latest hospitalization:

Date (YY/MM/DD)	Hospitalization reason	Hospital name

Relevant surgeries:

Specify the current health status, describe the illness's evolution since the past 3-6 month and possible outcome:

INVOLVED PROFESSIONALS

Name / First name of main physician or professional:

Hospital and attending physician:

Physician name:	Speciality	Hospital, clinic	Telephone

Name of family Doctor :

LEVEL OF CARE

Make a selection below and attach the official document signed by the doctor or medical team.
At any time, the child (over 14 years), the parent or the legal guardian, may change his mind about the level of care in accordance with the doctor. https://www.inesss.qc.ca/fileadmin/doc/INESSS/Rapports/OrganisationsSoins/Formulaire_NiveauxdeSoins_RCR.pdf

Objective A ☐
Prolonger la vie par tous les soins nécessaires.

Objective B ☐
Prolonger la vie par des soins limités

Objective C ☐
Assurer le confort prioritairement à prolonger la vie.

Objective D ☐
Assurer le confort uniquement sans viser à prolonger la vie

Date (YY/MM/DD):	Name / First name of physician:	Signature of physician :