Person Requesting Support:_____ Date of Birth _____

Person lives with:_____

Address:_____

City:_____

State:____ Zip:____ Text Phone:_____

Emergency Contact:_____

Phone:_____

What service(s) are requested?_____

What hours/schedule are being requested?

_____

Are there siblings in the home also requiring supervision? If Yes, please list below.

Sibling 1:_____DOB:_____
Sibling 2:_____DOB:_____
Sibling 3:_____DOB:_____

Official Diagnosis:
_____
_____
_____
_____
Seizures: Y/N
If Yes, is there a seizure protocol we can get a copy of?_____

Rescue Medications:_____

Routine Medications:
_____
_____
_____
_____

Continent:_____

If No, is there a potty schedule?_____

Diet: _____

Allergies:
_____
_____
_____
_____

Any behavioral Concerns such as:

Flight risk_____

No safety awareness_____

Aggressive behaviors_____ If Yes, are there triggers?
_____
_____

Preferred
Hospital:_____

DNR: Yes_____ NO_____

Male or Female Provider? :_____
Ideal Provider Traits?_____

How did they hear about
us?:_____

Who is the Resource Exchange case coordinator?
_____

Preferred
Activities:_____
_____
_____
_

Pets in
home:_____

If the client decides they want our services, please remind them to contact TRE and have Pikes Peak Respite Services added into their service plan.