BALUCHON
Répit long terme à domicile

REQUEST FOR BALUCHONNAGE

REFERENCE FORM FOR BALUCHON LONG-TERM CARE

To return by e-mail only : formulaire@baluchonrepit.com

Only one baluchonnage request per form. Allow an average processing time of 6 weeks. Requests can be sent up to 3 months before the month requested

SOURCE

Date : _____

CIUSSS/CISSS : _____

CLSC : _____

Name of contact healthcare worker :_____

Title/role of contact healthcare worker :_____

Phone and extension : _____

Email:_____

Fax : _____

Number of days authorized: _____

Name of client (care recipient): _____

Baluchonnage dates (First choice) : _____

Baluchonnage dates (Second choice): _____

Flexible dates? Yes ☐ No ☐

Signature of program manager (if required, according to internal procedure):_____

Name of program manager: _____

Date : _____

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CLIENT IDENTIFICATION

CARE RECIPIENT

Mr ☐ Mrs ☐

Name : _____

First Name : _____

Address : _____

City : _____

Postal code : _____

Phone : _____

Date of birth : _____

Language(s) used : _____

CAREGIVER

Name : _____

First name : _____

Address (if different): : _____

City : _____

Postal code : _____

Home phone: _____

Cell phone:_____

Relationship :

Email :_____

Language(s) used: : _____

I authorize _____ (name), _____ (title) to transmit relevant information to Baluchon Répit long terme during the processing of my request

Signature of caregiver : _____ Date : _____

OR

Verbal authorization from caregiver ☐ Date : _____

Main diagnosis: _____
Date of main diagnosis : _____

Secondary diagnosis : _____

Is the person in palliative care: _____ **At the end of life :** _____

ISO-SMAF number : _____ **Evaluation date :** _____

PHYSICAL FACTORS

Mobility : Autonomous ☐ Partial assistance ☐ Full assistance ☐

Further details : _____

Number of people required for transfers : _____

Does the caregiver use a lift or any other technical aid?

_____

Continence : Normale ☐ Urinary incontinence ☐ Fecal incontinence ☐

Occasional/frequent - day/night :

_____

Physical care (e.g., wound treatment, special diet, oxygen requirements, injections, etc.) :

Please specify: _____

DAILY LIVING ACTIVITIES

	Autonomous	Partial assistance	Full assistance
Eating			
Hygiene			
Getting dressed			
Bathroom			
Take medication			

Additional details:

_____

_____

NARCOTICS

Does the person's medication include narcotics? : **Yes** ☐ **No** ☐

If yes, please enter the nurse's name and contact information in the file:

ENVIRONMENTAL FACTORS

Type of home : _____

Persons living in the same household : _____

Psychosocial environment : _____

Animals : _____

PSYCHOLOGICAL AND MEDICAL FACTORS

Behaviours / issues / special situations : _____

_____

Relevant medical and surgical history: _____

_____

_____

SERVICES ET ACTIVITÉS

Nature et fréquence

From the CLSC :

_____

_____

If the request concerns a person in palliative/end-of-life care at home, does the caregiver have the support of a care team assigned to the family and available 24 hours a day? Please note that the presence of such a team will influence the assessment of the request. ☐ ***Yes*** ☐ ***No***

Other organizations: _____

_____

Services provided by the CLSC and its partners must be maintained during the baluchonnage period, unless otherwise specified. Refusal to maintain services may lead to cancellation.

PLEASE ATTACH THE FOLLOWING TO THE REQUEST:

- Pharmacological profile ☐
- OEMC / SMAF (if necessary, by e-mail only) ☐
- Any relevant specialized reports: occupational therapy, physiotherapy or others (if necessary, by e-mail only) ☐