Hopewell Outreach Service

Agency Request For Respite Funding

Approved:	Outreach Coordinator
Effective Date:	8/2012
Review Date:	8/2015
Updated	02/2014
Code:	SD 3.8.3-1 (FO)

Client:________________________________**DOB:**________
Address____
Phone:____
Email:____

Carer ____
Address:____
Phone:____
Email:____
_(If Different from above)

Please email request to: Outreach@hopewell.org.au

Clients registered with Gold Coast Supportive and Palliative Care Service are eligible for respite care:
Client Reference Number: ____

Requested By: ____________________________________ ***Date:*** ______________________

GCHHS	☐	Branch:	Carestaff	☐	Branch:
Anglicare	☐	Branch:	Blue Care	☐	Branch:
Ozcare	☐	Branch:	**PH:......................**		**Fax:.........................**

Respite Care Request: RN EN AIN (Please Circle)

Week Commencing Monday	Days Required	AM (Hours)	PM (Hours)	Night (Hours)	Saturday (Hours)	Sunday (Hours)	Total Hours This Week
04/02/13	*2200 Monday-0600 Tuesday*			*8*			*8*

***** Please do not commit to providing respite care until approval has been received from Hopewell***

Comments:

Diagnosis & Prognosis:

RUG/ADL: **AKPS:** ______________________

PHASE:

Hopewell Office Use Only

Agency Providing Service	Advised-Phone/email/fax	Person Notified	Date
Approved By:	Signature	Date	
RIP Date:	Place: Home ☐ Hospital ☐ Nursing Home ☐		