UCI#:_____

SDRC S.C._____

Unit: _____

Nursing Level Respite Services Report For San Diego Regional Center

Name:_____**DOB:**_____

Diagnosis:_____

Check & Describe Applicable Treatments/Conditions. Note if Discontinued.

Tube Feeding: Type_____Freq._____If p.r.n. Describe_____

Suctioning: Type_____Freq._____ If p.r.n. Describe_____

Trach &/or Ventilator: ☐ Trach ☐ Ventilator ☐ Both

Apnea Monitor: ☐ Continuous ☐ Intermittent ☐ Freq. of Alarms_____

Intervention_____

Nebulizer: Type_____Freq._____If p.r.n. Describe_____

O_2 Therapy: Type_____Freq._____If p.r.n. Describe_____

_____

Seizures: Freq._____ ☐ **Respiratory Compromise.** Interventions-Describe_____

_____

☐ **Cast Care** **Treatments/Wound Care/Dressings**-Describe_____

_____

Complicated Feeding Issues: Duration_____Positioning_____Aspiration Risk_____

High-Risk Cardiopulmonary:_____

Hospitalizations : (Most Recent) Date:_____Reason:_____

☐ **Regular Interruption of Family's Sleep**_____

Disruptive Behaviors of:_____

Medications: (List any rectal and parenteral meds., IM, TPN, etc.)_____

_____

List all changes in the past 6 months:_____

_____

Significant Social Changes:_____

_____

Other :_____

Number of Hours per Month:_____ _____

☐ **NOT USING RESPITE SERVICE**

AGENCY_____ DATE _____

VENDOR NAME:_____ DATE _____

SIGNATURE_____, R.N./L.V.N.

REPORTS ARE DUE TWICE A YEAR - JUNE AND DECEMBER

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