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| Resident Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Family Member Requesting Companion Care:**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact Information: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date requested: (dd/mm/yyy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Companion Care Details:**  Expected Date to Commence Long- Term Companion Care: (dd/mm/yyy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Temporary Service Required: Yes No Number of hours per day \_\_\_\_\_\_\_\_ per week \_\_\_\_\_\_\_  Expected Date to Commence Companion Care: (dd/mm/yyy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Expected Date to End Companion Care: (dd/mm/yy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please check the days of the week you expect companion care below:  00  Monday Tuesday Wednesday Thursday Friday Saturday Sunday |
| **Reason for Companion Care Request:**  Address behaviors ex. aggression, wandering, restlessness    Social Isolation    Recreational purposes    Accompany resident to off-site social events    Accompany resident to off-site appointment *(if check marked, refer to next line)*    Appointment Date: (dd/mm/yyy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Appointment Time: \_\_\_\_\_\_\_\_\_\_\_\_\_  Appointment Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Companion Hourly Rate:**  To accompany residents to off-site appointments is $23.00/ hour  On-site companionship is $20.00/ hour |

**COMPANION REQUEST FORM**

Signature: Family Member/ Resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Clinical Lead or Designate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Companion Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_