



XAVIER CHILDREN'S SUPPORT NETWORK



CARE PLAN

IF RECEIVING IN-HOME RESPITE CARE ONLY – COMPLETE PART A (YELLOW)
IF RECEIVING STRUCTURED RESPITE – COMPLETE PART A (YELLOW) & PART B (BLUE)

CARE PLAN – PART A

DATE: UPDATED: UPDATED:

CHILD'S FULL NAME: D.O.B.:

ADDRESS:
P/C:

MOTHER: FATHER:

SIBLINGS:
.....

PHONE:(H)(W)
.....(M)
if no mobile number, please provide one other emergency contact

NAME: NUMBER:

PLEASE PROVIDE A DESCRIPTION OF YOUR CHILD'S DISABILITY:
.....
.....

PLEASE LIST KNOWN ALLERGIES – FOOD & MEDICATION:

Nil Known

Allergies:

Reaction:

.....
.....
.....
.....

MEDICARE NO: HEALTH CARE CARD NO:

WHICH HOSPITAL DOES YOUR CHILD USUALLY ATTEND?:

FAMILY DOCTOR: TELEPHONE:

GENERAL HEALTH (colds, chest infections, ear aches):
.....
.....

Ongoing Concerns (Reflux; hips; etc):
.....

EPISODES OF ILLNESS:
(Temperatures, wheezing, irritability etc)



Procedure for Carer to Follow:

1.
2.
3.
4.

EPILEPSY: N/A

Description of Seizures (including how long they usually last):

Frequency:

Triggers:

Warning Signs:

Do you wish to be contacted if your child has a seizure while in the care of Xavier staff?: Yes No

EMERGENCY PROCEDURE FOR CARER TO FOLLOW:



1.
2.
3.
4.

PLEASE NOTE IF YOUR CHILD EXPERIENCES A LIFE THREATENING EVENT, XAVIER CARERS WILL

*Call an ambulance

*Contact the parents

*Contact Xavier Registered Nurse

*Accompany child to hospital in the ambulance

*Wait for parents/guardians to arrive

NUTRITION:



How does your child eat/drink? (please ✓) Oral Naso-Gastric Gastrostomy Combination

NASO-GASTRIC/GASTROSTOMY: N/A

If naso-gastric tube or gastrostomy button, please indicate:- **Type:** **Size:**

Feeding Regime: (please ✓) Bolus Continuous Combination

Formula:

Additives:

Quantity, Times & Rates:

Care of Gastrostomy Button Site: Please indicate preferred lotion:

Is a dressing required? e.g. softwick Yes No

ORAL: N/A



Preferred Foods/Drinks:

Consistency of Food: Cut Mashed Pureed

Foods/Drinks to Avoid:

Formula: Amount: Frequency:

Special Cup/Teat:

Special Utensils:

RECREATION:



What activities does your child enjoy:

Any activities your child particularly dislikes:

SAFETY & BEHAVIOUR:



Does your child have any behaviour which carers need to be aware of:

.....
.....
.....
.....

If yes, how do you manage this behaviour:

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.....
.....
.....

MOBILITY:



How does your child mobilise:

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.....

Preferred way of Lifting your Child:

- Hoist One Person Lift Two Person Lift Other

Favourite positions:

Positions to avoid:

.....

Positions to encourage:

.....

COMMUNICATION:



How does your child communicate their needs:

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.....
.....

ELIMINATION:



If your child is on a toilet training programme, please provide details:

On average, how many nappies does your child require per day?:

Please indicate preferred hygiene products/lotions etc:

HEARING AND VISION: N/A

(please ✓)



Hearing Loss: Mild Moderate Severe

Wears Hearing Aids: Yes No

Grommets: Yes No

Vision Impairment: Mild Moderate Severe

Wears Glasses: Yes No

OXYGEN & SUCTIONING N/A

Does your child have oxygen at home? No Yes – If yes, what is the frequency:

What is the Rate?:

How is it delivered (prongs/mask, etc):

Does your child require suctioning?: No Yes – If yes, please provide details (frequency):

IS THERE ANY OTHER INFORMATION YOU BELIEVE WOULD BE HELPFUL TO XAVIER CARERS?:

.....

CHILD'S FULL NAME:

TRANSPORTATION:

How is your child transported?
(please ✓)

- Car: Baby Car Seat
- Booster Seat
- Columbia



And/or

Van:

In accordance with Australian Standards, Xavier Staff are INSTRUCTED to transport children in vans with their head rest ON (if they have one), tray OFF and the wheelchair as upright as possible.

If you require any variation to the above, please speak to your Keyworker or Therapist and request an assessment.

The assessment results will be documented below.

ASSESSMENT:

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OUTCOME:

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Parent's Name:

Parents Signature:

CARE PLAN – PART B

CHILD'S FULL NAME:

HYGIENE:



Bath Shower Grommets Yes No

Xavier staff are not to cut nails without seeking permission from parents. Do you give Xavier Staff permission to cut/trim your child's nails? Yes No

Bath Aid? Yes No If Yes, please specify:

Preferred time:

Particular fears:

Preferred soaps/lotions:

SLEEPING:



Bed Time: Waking Time:

DayTime Rest: No Yes - what timesampm

Nighttime sleeping pattern and desired response from carer:

Preferred sleeping position:

Child Sleeps in a: low sided cot high sided cot bed with rails bed without rails

Child Sleeps with Lights: On Off Child Sleeps with Door: Open Closed

NUTRITION:



Do you wish to provide any further information regarding feeding or nutrition not covered in Part A.

EDUCATION: N/A



School Attended: Phone:

School Address:

School Transport Required: No Yes - Taxi Bus Other

Child Attends: Full Time Part Time - days hours

Equipment to go with Child to School:

Parent's Name:

Parents Signature:

