



77 ACADEMY STREET

NEWARK NJ 07102

973-643-0400

[NEWS AND EVENTS](#)[NEWS AND EVENTS](#)[ABOUT US](#)[OUR PROGRAMS](#)[CONTACT](#)[VOLUNTEER](#)[DONATE](#)[FOR DCP&P](#)

St. Clare's Homes - Respite Referral Form

St. Clare's Homes are contracted with the NJ Division of Child Protection & Permanency (DCP&P) to provide transitional housing and comprehensive services to children with specialized medical needs.

Links to Resources to help DCP&P match a case with St. Clare's Homes:

- [List of Services Provided at St. Clare's Homes & Common Diagnoses in Admitted Children](#)
- [Admissions Requirements](#)
- [Referral Form](#)

- * **Limited Emergency Referrals** can be accommodated by calling Debra Leib at (908) 351-8746
- * **Limited Availability for Older Children** Ages 13-16

The form below can be printed, completed, and submitted to Debra Leib via email at dleib@stclaresservices.org or fax at (973) 242-3583. Debra can also be contacted at (908) 351-8746.

RESPITE REFERRAL FORM

Child's Name:

Date of Birth:

Respite Stay Dates:

Diagnosis:

Medication: _____ **Dosage:** _____

Time(s): _____ **Route:** _____

Medication: _____ **Dosage:** _____

Time(s): _____ **Route:** _____

Medication: _____ **Dosage:** _____

Time(s): _____ **Route:** _____

Medication: _____ **Dosage:** _____

Time(s): _____ **Route:** _____

Medication: _____ **Dosage:** _____

Time(s): _____ **Route:** _____

Medication: _____ **Dosage:** _____

Time(s): _____ **Route:** _____

Diet/Routine

Formula/Milk & Schedule:

Baby Food - Stage_____

Regular Diet

Pureed

Table Food

Feeds Self

Feeds Self with

Help

Total Feed

Tube Feeding: (List feeding times)

Diaper - size_____

Potty Trained

Ambulates Independently

Requires Adaptive Equipment: If yes, please list:

Food Likes:

Food Dislikes:

Food Sensitivities:

Food Allergies:

Sleeping Routine

Morning awake time: _____

Nap time(s): _____

Bedtime: _____

Nap and Bedtime Routine:

Activities

Please list the child's favorite indoor and outdoor activities:

Calming Techniques:

Please list any calming/soothing techniques if the child is

crying or upset:

Child Knows HIV/Medical Status: Yes No N/A

Comment:

Visitation Plan:

Will there be any visitors, including therapists, that will visit at St. Clare’s during this respite?

Yes No If yes, please complete information below:

Date: _____ Name: _____ Relationship to Child: _____ Day/Time: _____

Date: _____ Name: _____ Relationship to Child: _____ Day/Time: _____

Date: _____ Name: _____ Relationship to Child: _____ Day/Time: _____

Date: _____ Name: _____ Relationship to Child: _____ Day/Time: _____

Name of Person Completing the Form:

Signature: _____

Date: _____

Received by St. Clare’s

(date): _____



