***Demande d'accompagnement***

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| **Personne accompagnée**  Normalement c'est la personne qui a besoin d'accompagnement qui fait la demande, sur référence de la part d'un professionnel de la santé ou autre. Si elle en est incapable, c'est un professionnel de la santé, un proche ou un ami qui le fait pour elle. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Nom :** (Monsieur, Madame, autre) : | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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|  | **Prénom** | | | | | | | | |  | | **Nom de fille (le cas échéant)** | | | | | | | | | | | | | |  | | | | **Nom de famille** | | | | | | | | | | | |  | |
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| **Date de naissance :** | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Adresse :** | |  | | | | | | | | | | | | | | | | | | | | **Ville :** | | | | |  | | | | | | | | | | | | | | |  | |
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| **Province :** | |  | | | | | | | | | | **Code postal :** | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | |
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| **Tél. résidence :** | | | | | ( |  | | | ) | |  | | - | |  | | | | | | **Tél. Cellulaire :** | | | | | ( | | |  | | | ) | | |  | | - | |  | |  | | |
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| **Personne à joindre pour urgence :** | | | | | | | | | | | | | | | |  | | | | | | | | **Tél :** | | ( | | |  | | | ) | | |  | | - | |  | |  | | |
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| **Adresse courriel :** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Langues parlées :** | | | | | |  | | **Français** | | | | | | | | |  | | | **Anglais** | | |  | | | | | | | | | | | | | | | | | | | | |
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| **Renseignement sur votre santé** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Situation :** | | | | | |  | | **Maladie grave** | | | | | | | | |  | | | **Soins palliatifs** | | | | | | | | | | | | | | | | | | | | | | | |
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| **Information :** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Signature de consentement**  Signature de consentement de la personne accompagnée ou de son représentant. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Signature :** | | | |  | | | | | | | | | | | | | | | | | | | | | **Date :** | | | | | | | | |  | | | | | | | |  | |
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| **Lien avec la personne accompagnée :** | | | | | | | | | | | | | | | | | |  | | | | | | | **Tél :** | | | ( | | |  | | ) | | |  | | - | |  | | |  |
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| **Référence**  Professionnel de la santé ayant fait la référence (le cas échéant) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Nom :** (Monsieur, Madame, autre) : | | | | | | | | | | | |  | | | | | | | | | | | | | | |  |
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|  | **Prénom** | | | | | | | |  | | **Nom de fille (le cas échéant)** | | | | | |  | | | **Nom de famille** | | | | | | |  |
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| **Professionnel :** | | | | |  | | **Médecin** | | | | | |  | **Infirmier(ère)** |  | **T.S.** | | | | | | | | | | | | |
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| **Autre :** | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | |
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| **Établissement :** | | | | |  | | **CH** | | | | | |  | **CHSLD** |  | **CLSC** | | | | | | | | | | | | |
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| **Autre :** | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | |
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| **Tél. réf. :** | | ( |  | ) | |  | | - | |  | | | **Tél. organisme :** | | | ( | |  | | | ) |  | | - |  |  | | |
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| **Signature du professionnel de la santé**  Signature du professionnel de la santé ayant fait la référence (le cas échéant) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Signature :** | | |  | | | | | | | | | | | | | | | | **Date :** | | | |  | | | | | |
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| **Accompagnement demandé**  Identifiez l'endroit où l'accompagnement aura lieu et la plage horaire désirée. | | | | | | | | | | | | | | | | | | | | | |
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| **Lieu d'accompagnement :** | | | | |  | **RPA** | | | |  | **CHSLD** | |  | | | **Hôpital** | |  | **Domicile** | | |
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| **Adresse :** | |  | | | | | | | | | | | | | **# de chambre :** | | | |  | |  |
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| **Date du début de**  **l'accompagnement :** | | |  | | | | |  | Plus d'info : | | | | | | | | | | | |  |
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| **Plage horaire demandée** | | | | | | | | | | | | | | | | | | | | | |
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|  | **Lundi** | | | **Mardi** | | | **Mercredi** | | | | | **Jeudi** | | **Vendredi** | | | **Samedi** | | | **Dimanche** | |
| **Matin** |  | | |  | | |  | | | | |  | |  | | |  | | |  | |
| **Après-midi** |  | | |  | | |  | | | | |  | |  | | |  | | |  | |
| **Soirée** |  | | |  | | |  | | | | |  | |  | | |  | | |  | |
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***Entente préalable à l'accompagnement***

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| **Services** | | | | | | | | | | | |
| Albatros est un mouvement dont l'agir ne doit jamais outrepasser ce qu'un parent (père ou mère) pense bon de faire en certaines circonstances, ou ce qu'il ferait pour son enfant.  Ce service est rendu à partir de la demande explicite du bénéficiaire, de la famille, ou d'une personne significative pour le bénéficiaire.  Le personnel soignant demeure l'autorité quant aux soins et services professionnels à être donnés.  Prenant en considération ces prémices :   * L'administration de médication, dans le cadre d'un accompagnement à domicile, nécessite une **autorisation écrite de la famille** en l'absence de celle-ci; * **Aucune manipulation visant à déplacer le malade** n'est permise en l'absence de la famille. | | | | | | | | | | | |
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| **Personne accompagnée (patient)** | | | | | | | | | | | |
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| **Nom :** (Monsieur, Madame, autre) : | | | | |  | | | | | |  |
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|  | **Prénom** | |  | **Nom de fille (le cas échéant)** | | | |  | **Nom de famille** | |  |
|  | | | | | | | | | | | |
| **Signature de consentement de la personne significative** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Signé à :** | |  | | | | | **Date :** | | | JJ/MM/AAAA |  |
|  | | | | | | | | | | | |
| **Signature :** | |  | | | | | | | | |  |
|  | | | | | | | | | | | |
| **Lien avec la personne accompagnée :** | | | | | |  | | | | |  |
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**Coordonnatrice de l'accompagnement bénévoles**

Albatros Gatineau - La Lièvre au 873-455-9632

AlbatrosGatineauLL@gmail.com