REQUEST FOR ESSENTIAL CAREGIVER
THE PINES LTC HOME

A caregiver is a type of essential visitor who is designated by the resident and/or their substitute decision-maker (Power of Attorney) and is visiting to provide direct care to the resident.
Please complete and return this form to the Director of Care (DOC) at The Pines, only if you wish to apply to have designated caregivers assigned to a resident in our home.
If you do not apply to be a caregiver, general visits (indoor) are still available. All applications will be reviewed by the Nursing Leadership Team (DOC/ADOC) and you will be notified within 7 business days of the status of your application.
A form must be signed by the resident or substitute decision-maker only; no limit on number of caregivers per resident.

Resident's Name:_____**ROOM #** _____

☐ **SPRUCE** ☐ **CEDAR** ☐ **OAK** ☐ **BIRCH** ☐ **MAPLE**

CAREGIVER

Which of the following support(s) you will be providing?
Please check applicable boxes below:

☐ Support with eating/meals (eg: supervise and assist with meals—*some training may be involved)
☐ Cognitive Stimulation (eg: reading/music/conversation)
☐ Personal Hygiene (eg: hair grooming, nail care)

PanBIO Rapid Antigen Testing is available Monday- Sunday from 9:00am to 4:30pm, please also note that staff require break times and there might not be an employee immediately available to assist you. We will attempt to complete your testing as soon as possible.

HEALTH SERVICES DEPARTMENT
Long-Term Care Services
70 Pine Street, Bracebridge, ON P1L 1N3
Phone: 705-645-2100 **Toll-Free:** 1-800-461-4210 (within 705)
Fax: 705-645-5319
Email: healthservices@muskoka.on.ca
Website: www.muskoka.on.ca

THE PINES
Long-Term Care Home
98 Pine Street, Bracebridge, ON P1L 1N5
Tel: 705-645-4488
Fax: 705-645-6857

CAREGIVER

Which of the following support(s) you will be providing?
Please check applicable boxes below:

☐ Support with eating/meals (eg: supervise and assist with meals—*some training may be involved)
☐ Cognitive Stimulation (eg: reading/music/conversation)
☐ Personal Hygiene (eg: hair grooming, nail care)

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I AM A RESIDENT Name:_____ Room Number: _____

CAREGIVER Name (Please Print):_____ Substitute Decision-Maker (Power of Attorney)

Signature: _____

Date: _____

CAREGIVER Name (Please Print):_____ Substitute Decision-Maker (Power of Attorney)

Signature: _____

Date: _____

*****Please return this application to the attention of: Tara Maclellan, Director of Care*****

******DOC/ADOC USE ONLY BELOW THIS LINE******

Date Received:_____ Date Reviewed:_____ Approved: YES ☐ NO ☐

Not Approved (please explain here):