island health

APPROVED ESSENTIAL VISITOR PLAN RESIDENT LABEL

Site/Unit: _____ Date: _____

Essential Visit Plan Approved by: _____ _____
(Signature of Site Representative, Designation) (Signature of Essential Visitor)

APPROVED ESSENTIAL VISIT PLAN	
Essential Visitor Name	
Contact Information	
RATIONALE/NEED: Why are essential visits required? Check all that apply AND add a supporting comment below	
Essential Care Needs due to Compassionate Care	
☐	Critical Illness
☐	Palliative Care, Hospice Care, End of Life and Medical Assistance in Dying
Essential Care Needs due to Physical Care and Mental Well-Being	
☐	Assistance with feeding
☐	Mobility and Personal Care / ADLs
☐	Assistance by Designated Representatives for Persons with Disabilities
☐	Translation or Communication
☐	Supported Decision Making
☐	Existing registered volunteer for services above
Essential Care Needs: Other	
☐	Visits required to move belongings in/out of a resident's room
☐	Police, correctional officers and peace officers accompanying a resident for security reasons
Comments	
VISIT SCHEDULE	
Date of First Visit:	
Date(s) of Monthly Review:	
Visit Schedule, if applicable	
Visit Time of Day:	
Visit Length:	
Additional comments or considerations	