



Respite Rx
Risk Assessment & Agreement

Caregiver Name:	Date:
Program Coordinator:	

Description of Service Change Being Considered:
Options Discussed:
Potential Risks:

I, _____, have discussed the potential risks and understand there are other service options that may help to reduce or eliminate those risks. I take full responsibility for my choice to pursue the following options:

Caregiver Signature: _____ Date: _____

Program Coordinator Signature: _____ Date: _____