

CONTACT INFORMATION

Name: (Last) _____ (First) _____ Gender: M F

Address: _____ Lock box #: _____ Apt. Intercom: _____

City: _____ Postal Code: _____ Phone: _____

Residence type: _____ Client Lives: Alone With Family Alone, family in town Other: _____

Birth Date: _____ (yy/mm/dd) Languages: English Punjabi Cantonese Other: _____

Emergency Contacts:

1) _____ Phone: _____ Phone: _____

2) _____ Phone: _____ Phone: _____

Physician: _____ Phone: _____ Health #: _____

Power of attorney: _____ Phone: _____

Bill to (if different from above): _____

Referred By: Hospital LTC End of life Rehab Acute QRP
 DVA: personal care DVA: cleaning ICBC MCF&D Private/Other:

Referral Contact: _____ Phone: _____

Office code: _____ Order #: _____

LTC Client #: _____ Client Fee: _____

Medical History & Diagnosis:

Cognitive Function: _____ DNR Location: _____

Authorized Hours: _____

Start Date: _____ Re-assess / Expiry Date: _____ Essential Services Stat Services

WORKPLACE RISKS IN HOME

	History	Current Status
Violent/Aggressive Behaviour or Resistive to Care		
Unauthorized visitors		
Communicable Diseases		
Sharps		
Cytotoxic Drugs: Chemo/radiation		
Controlled Substance Usage: Drugs Alcohol		
Smoking		
Household Pets		
Weapons		
Other		

CLIENT SERVICE INFORMATIONHearing: _____ Aids: L R Vision : _____ Glasses: Yes NoContinent: Bowel Yes No Bladder Yes No Continance Pad Yes No

Mobility Independent Supervised (Stand By) Verbal Cueing Minimal Assist (1 Person Transfer)
 Moderate Assist (1-2 Persons &/or Device) Dependent (No Manual Transfer)

Equipment Wheelchair Scooter Canes Hand held shower
 Other (list): _____ Walker Grab bars Bath bench/stool

Personal Assistance Bath Shave Transferring Dressing Respite
 Bed bath Shampoo Repositioning Perineal Care Ready for bed
 Sponge bath Skincare Walking Toileting
 Cueing/Coaching: _____ Other: _____

Delegation of Tasks:

General Cleaning Kitchen Laundry Bed Change Vacuum
 Bathroom Shopping Wash Floor Dusting
 Other: _____

Periodic Cleaning Oven Fridge Inside Windows

Meal Preparation: _____**Diet Instructions (Including Allergies):** _____ Allergies: _____

Community Support Adult Day Care Home Care Nurse Mental Health Worker Other:
 Handidart Lifeline Rehabilitation Therapist
 Nutritionist Hospice Meals on Wheels

Does the Community Health Worker provide childcare? Yes No

Children's names:

1) _____ DOB _____ Allergies _____

2) _____ DOB _____ Allergies _____

Unauthorized visitors: _____

Other information: _____**Comments:**Copies to: Area Scheduler RN/CC/LPN Accounting Other: _____