

Home Care Program

Short Term Assessment/Hospital Discharge and Basic Information Form

Proceed with admission to Home Care: _____
 Date services to begin: _____
 Other actions: _____

 Case Coordinator

PHIN No.		Home Care No.			
Date of referral		Coordinator's name & agency/area			
<input type="checkbox"/> new <input type="checkbox"/> resume <input type="checkbox"/> reopened		Agency to be billed			
Client's name (Surname)		(Given Names)	Sex	Birthdate	Phone number
				DD MMM YYYY	
Home address		Street Address			Postal Code
PO Box No					
Band name	Treaty number	Registration no.		Social Insurance No.	
Region	Area	Can person communicate in English?		If not, which language?	
Present location: <input type="checkbox"/> Same as above address <input type="checkbox"/> Hospital <input type="checkbox"/> Hostel <input type="checkbox"/> Nursing home <input type="checkbox"/> Home of relative <input type="checkbox"/> Room & board/foster home <input type="checkbox"/> Other (specify) _____					
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/separated <input type="checkbox"/> Other					
Next of kin or person responsible - Name			Relationship		Phone number
Address					Postal code
Next of kin or person responsible - Name			Relationship		Phone number
Address					Postal code
Person making referral:			Relationship/agency		Phone number
Address					Postal code
Physician's name		Address		Postal code	Phone number
Physician's name		Address		Postal code	Phone number
Physician's name		Address		Postal code	Phone number

Surgical procedures and date

Hospital admission date: _____

Diagnosis: _____ /Extent of disability

Discharge date: _____

Allergies: _____

Diagnosis known:

Reason for referral: _____

To family **To person**

Yes

Yes

No

No

Recommended/requested supports: _____

Prognosis:

A. Rehabilitation

B. Maintenance at present

C. Deterioration likely

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Client's name _____
(Surname) (Given names)

Discharge medications/treatment: _____

Diet:

Living arrangement:

- Alone
- With relatives
- With others

Family support:

- Not available
- Minimal
- Moderate
- Complete

Daily living:

- Is patient or other family members able to:
- Prepare meals: Yes No
- Do the shopping: Yes No
- Do the housekeeping: Yes No
- Arrange own activities: Yes No

Environment:

- Satisfactory
- Unsatisfactory (explain)

Comments: _____

Other agency involvement: Agency: _____
Service provided: _____

Service recommended:

- Nursing _____
- Therapy PT OT _____
- Home care attendant/orderly _____
- Homemaking _____
- Day hospital _____
- Meal delivery _____
- Adult Day Program _____
- Other (specify) _____

Nature/type of service:

Amount and frequency:

Supplies and/or equipment requested: _____

1 AMBULATION				
<input type="checkbox"/>	Unlimited cor s mech. aid	<input type="checkbox"/>	Outdoors with aid	
<input type="checkbox"/>	Indoors, semi-amb	<input type="checkbox"/>	Indoors, semi-amb with aid	
<input type="checkbox"/>	Wheelchair independent	<input type="checkbox"/>	Wheelchair with aid	
<input type="checkbox"/>	Bed to chair	<input type="checkbox"/>	Bed to chair with aid	
<input type="checkbox"/>	Bedfast - can turn self	<input type="checkbox"/>	Bedfast - must be turned	
<input type="checkbox"/>	Other			
2 CONTINENCE				
<input type="checkbox"/>	Completely continent	<input type="checkbox"/>	Incontinent urine, occ.	
<input type="checkbox"/>	Incontinent urine, always	<input type="checkbox"/>	Indwelling catheter	
<input type="checkbox"/>	Incontinent feces, occ.	<input type="checkbox"/>	Incontinent feces, always	
<input type="checkbox"/>	Colostomy	<input type="checkbox"/>	Other	
3 MENTAL STATUS				
<input type="checkbox"/>	Completely orientated	<input type="checkbox"/>	Mildly confused, occ.	
<input type="checkbox"/>	Mildly confused, always	<input type="checkbox"/>	Moderately confused, occ.	
<input type="checkbox"/>	Moderately confused, always	<input type="checkbox"/>	Depressed	
<input type="checkbox"/>	Overly anxious	<input type="checkbox"/>	Bizarre behaviour	
<input type="checkbox"/>	Other			
4 PERSONAL CARE ASSISTANCE				
Bathing	Dressing	Toileting	Feeding	
				- No help needed
				- Minimum help
				- Moderate help
				- Complete help