

Home Care Program

TRANSFER FORM - AGENCY TO AGENCY

TO: _____

FROM: _____

DATE OF TRANSFER: _____

PHIN: _____

CLIENT'S NAME	SURNAME	GIVEN NAMES	SEX	BIRTHDATE D M Y	PHONE NUMBER
HOME ADDRESS					POSTAL CODE
BAND NAME		TREATY NUMBER			MHSC NUMBER
REGION	AREA OFFICE	CAN PERSON COMMUNICATE IN ENGLISH? <input type="checkbox"/> YES <input type="checkbox"/> NO			IN WHICH LANGUAGE DOES PERSON COMMUNICATE BEST?
PRESENT LOCATION		SAME AS ADDRESS 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
PHYSICIAN'S NAME					PHONE NUMBER
ADDRESS					POSTAL CODE
DIAGNOSIS (EXTENT OF DISABILITY)					DIAGNOSIS KNOWN: TO FAMILY TO PERSON <input type="checkbox"/> YES <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO
COMMUNICATION (SPECIFY IF PROBLEM)					
MEDICATIONS			PRESENT TREATMENTS		
UNDERSTANDS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PARTIAL			VITAL SIGNS		
COMPLIANCE <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PARTIAL					

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1. Ambulation
- | | |
|---|---|
| <input type="checkbox"/> Unlimited with or without much aid | <input type="checkbox"/> Bed to chair |
| <input type="checkbox"/> Outdoors with assistance | <input type="checkbox"/> Bed to chair with assistance |
| <input type="checkbox"/> Indoors, amb. with assistance | <input type="checkbox"/> Bedfast - can turn self |
| <input type="checkbox"/> Wheelchair independent | <input type="checkbox"/> Bedfast - must be turned |
| <input type="checkbox"/> Wheelchair with assistance | <input type="checkbox"/> Cannot manage stairs |
| | <input type="checkbox"/> Stairs with assistance |
| | <input type="checkbox"/> Stairs independent |

Reason: _____

Current Management: _____

Planned Intervention: _____

2. Elimination
- | | |
|---|--|
| <input type="checkbox"/> Completely continent | <input type="checkbox"/> Incontinent feces, always |
| <input type="checkbox"/> Incontinent urine, night only accident | <input type="checkbox"/> Completely incontinent |
| <input type="checkbox"/> Incontinent urine, always | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Incontinent feces, occ. | |
| <input type="checkbox"/> Retention of urine | |

Reason: _____

Current Management: _____

Planned Intervention: _____

3. Mental Status
- | | |
|--|--|
| <input type="checkbox"/> Completely oriented | <input type="checkbox"/> Depressed |
| <input type="checkbox"/> Forgetful, occ. | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Confused, etc. | <input type="checkbox"/> Bizarre behaviour (specify) |

Reason: _____

Current Management: _____

Planned Intervention: _____

4. Personal Care
- Bathing
- | | |
|---|--|
| <input type="checkbox"/> Independent with shower or bath | <input type="checkbox"/> Can bathe only with supervision, assistance |
| <input type="checkbox"/> Independent with mechanical aids | <input type="checkbox"/> Has to be bathed |
| <input type="checkbox"/> Can sponge bath self | |

Reason: _____

Current Management: _____

Planned Intervention: _____

- Dressing
- | | |
|---|--|
| <input type="checkbox"/> Independent | <input type="checkbox"/> Can dress/undress with minimal assistance |
| <input type="checkbox"/> Independent with supervision | <input type="checkbox"/> Requires considerable assistance |
| | <input type="checkbox"/> Has to be dressed/undressed |

Reason: _____

Current Management: _____

Planned Intervention: _____

- Eating
- | | |
|---|---|
| <input type="checkbox"/> Independent | <input type="checkbox"/> Requires assistance or encouragement |
| <input type="checkbox"/> Independent with mechanical aids | <input type="checkbox"/> Has to be fed |
| <input type="checkbox"/> If food cup up | |

Reason: _____

Current Management: _____

Planned Intervention: _____

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Daily Functioning (Specify if any problem in shopping, preparation of meals, household cleaning, use of phone and/or household chores)

Reason: _____

Current Management: _____

Planned Intervention: _____

5. Social Functioning

Judgement in present environment

- | | |
|---|--|
| <input type="checkbox"/> Realistic | <input type="checkbox"/> Limited ability to make judgement |
| <input type="checkbox"/> Adequate for personal safety | <input type="checkbox"/> Unrealistic |

Reason: _____

Current Management: _____

Planned Intervention: _____

Living Arrangements

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Satisfactory | <input type="checkbox"/> Alone | <input type="checkbox"/> With Relative |
| <input type="checkbox"/> Unsatisfactory | <input type="checkbox"/> Bedridden | <input type="checkbox"/> Other (specify) _____ |
| | <input type="checkbox"/> Foster Home | |

Reason: _____

Current Management: _____

Planned Intervention: _____

Participation in Activities (Observations of worker. Please comment on each section)

a) How does the individual spend his/her time? _____

b) What other activities and contacts would the individual like to have? _____

c) Identify cultural and religious preferences relevant to the delivery of Home Care Services _____

Participation in Activities (as viewed by client) Satisfactory Unsatisfactory

Reason: _____

Current Management: _____

Planned Intervention: _____

