HOME CARE
TRANSFER FORM - AGENCY TO AGENCY

COMFORT AT HOME
TOGETHER WE CARE

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?	IN WHICH LANGUAGE DOES PERSON COMMUNICATE BEST?

PRESENT LOCATION SAME AS ADDRESS
OTHER (SPECIFY)

MARITAL STATUS: MARRIED _____ SINGLE _____ WIDOWED _____ DIVORCED/SEPARATED _____ 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 _____YES _____NO TO PERSON _____ YES _____ NO

COMMUNICATION (SPECIFY IF PROBLEM)

MEDICATIONS	PRESENT TREATMENTS
UNDERSTANDS YES _____ NO _____ PARTIAL _____	VITAL SIGNS
COMPLIANCE YES _____ NO _____ PARTIAL _____	

ASSESSMENT (continued)

1. Ambulation

_____ Unlimited with or without much aid
_____ Outdoors with assistance
_____ Indoors, amb. with assistance
_____ Wheelchair independent
_____ Wheelchair with assistance
_____ Bed to chair
_____ Bed to chair with assistance
_____ Bedfast - can turn self
_____ Bedfast - must be turned
_____ Cannot manage stairs
_____ Stairs with assistance
_____ Stairs independent

Reason: _____

Current Management: _____

Planned Intervention: _____

2. Elimination

_____ Completely continent
_____ Incontinent urine, night only accident
_____ Incontinent urine, always
_____ Incontinent feces, occ.
_____ Retention of urine
_____ Incontinent feces, always
_____ Completely incontinent
_____ Other (specify)

Reason: _____

Current Management: _____

Planned Intervention: _____

3. Mental Status

_____ Completely oriented
_____ Forgetful, occ.
_____ Confused, etc.
_____ Depressed
_____ Anxious
_____ Bizarre behaviour (specify)

Reason: _____

Current Management: _____

Planned Intervention: _____

4. Personal Care

Bathing

____ Independent with shower or bath
_____ Independent with mechanical aids
_____ Can sponge bath self
_____ Can bath only with supervision, assistance
_____ Has to be bathed

Reason: _____

Current Management: _____

Planned Intervention: _____

Dressing

_____ Independent
_____ Independent with supervision
____ Has to be dressed/undressed
_____ Can dress/undress with minimal assistance
_____ Requires considerable assistance

Reason: _____

Current Management: _____

Planned Intervention: _____

ASSESSMENT (continued)

4. Personal Care (continued)

Eating
_____ Independent
_____ Independent with mechanical aids if food cup up
_____ Requires assistance or encouragement
_____ Has to be fed

Reason: _____

Current Management: _____

Planned Intervention: _____

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
_____ Realistic
_____ Adequate for personal safety
_____ Limited ability to make judgement
_____ Unrealistic

Reason: _____

Current Management: _____

Planned Intervention: _____

Living Arrangements
_____ Satisfactory
_____ Unsatisfactory
_____ Alone
_____ Bedridden
_____ Foster Home
_____ With Relative
_____ Other (specify)

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: _____

ASSESSMENT (continued)

Social Functioning (continued)

Degree of Supportiveness of Family (as viewed by client)

____ Supportive _____ Non Supportive
_____ Sometime Supportive _____ Specify Nature of Support

Reason: _____

Current Management: _____

Planned Intervention: _____

Degree of Supportiveness of Friends/Neighbours (as viewed by client)

____ Supportive _____ Non Supportive
_____ Sometime Supportive _____ Specify Nature of Support

Reason: _____

Current Management: _____

Planned Intervention: _____

REASON FOR TRANSFER _____

_____

CARE PLAN AND GOALS (Summary) _____

_____

_____

_____

_____

_____

_____

PRESENT SERVICES: INDICATE FREQUENCY AND TYPE OF SERVICE BEING PROVIDED (If Applicable)

SERVICE	TYPE	SOURCE/AGENCY	FREQUENCY	ACTIVITY	AUTHORIZED
Nursing					
Therapy					
H.M.					
Meal Delivery					
Adult Day Program					
Day Hospital					
Equipment					
Supplies (Drsg. Etc.)					
Other					