

HOME CARE CASE ACTION FORM



1. CLIENT NAME: _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date: _____	D/M/Y
REGISTRATION #: _____	PHIN #: _____	Dementia: <input type="checkbox"/> Y <input type="checkbox"/> N	
ADDRESS: _____		Phone: _____	
<input type="checkbox"/> New Opening	OPEN FOR:	Age at Opening: _____	
<input type="checkbox"/> Re-opening	<input type="checkbox"/> Home Care Assessment and/or		
<input type="checkbox"/> Transfer in (specify) _____	<input type="checkbox"/> Personal Care Home Assessment	Transfer Date: _____	D/M/Y
	<input type="checkbox"/> Other (specify) _____		
		Opening Date: _____	D/M/Y
Case Assessors: Nurse: _____	Social Worker: _____		
Case Coordinator: _____			

2. NON-ADMISSION TO HOME CARE:	Non-Admission Date _____	D/M/Y
<input type="checkbox"/> Home Care Services Not Required (32)	<input type="checkbox"/> Admitted To a Care Facility Or Hospital (35)	
<input type="checkbox"/> Home Not Suitable For Home Care (33)	<input type="checkbox"/> Person Or Family Refused Service (36)	
<input type="checkbox"/> Person Deceased (34)	<input type="checkbox"/> Other (Specify) _____	

3. ADMISSION TO THE HOME CARE PROGRAM: <input type="checkbox"/> Admission <input type="checkbox"/> Re-Admission	Admission Date _____	D/M/Y
4. SOURCE OF REFERRAL FOR ADMISSIONS: (Check One)	<input type="checkbox"/> Self (A)	<input type="checkbox"/> Doctor (B)
<input type="checkbox"/> Hospital (C)	<input type="checkbox"/> Family/Friend (D)	<input type="checkbox"/> Other Agency (E)
<input type="checkbox"/> Own Agency (F)		
5. CARE LEVEL EQUIVALENT AT POINT OF ADMISSION/RE-ADMISSION: (If Home Care were not available, what equivalent level of facility care would be required for the individual?) (Check One)		
<input type="checkbox"/> Personal Care Home Level I (1)	<input type="checkbox"/> Acute Care (4)	
<input type="checkbox"/> Personal Care Home Level II (2)	<input type="checkbox"/> Hospital – Extended Care/Long Term (5)	
<input type="checkbox"/> Personal Care Home Level III (3)	<input type="checkbox"/> Other Facility (6) _____	
<input type="checkbox"/> Personal Care Home Level IV (8)	<input type="checkbox"/> No Facility Care Level Equivalent (7)	

6. DISCHARGE FROM THE HOME CARE PROGRAM: (Check One)	Discharge Date _____	D/M/Y
<input type="checkbox"/> Person Improved/Recovered (11)	<input type="checkbox"/> Service Provided By Other (18)	
<input type="checkbox"/> Person Deceased (14)	<input type="checkbox"/> Personal Care Home Placement (21)	
<input type="checkbox"/> Hospital Admission (15)	<input type="checkbox"/> Other (Specify) (25) _____	