

Manitoba Home Care Program



HOME CARE SHORT TERM ASSESSMENT/HOSPITAL DISCHARGE FORM 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 Day Month Year		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 Day Month Year		Phone number
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							
Next of kin or person responsible – Name				Relationship		Phone number	
Address							

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: _____

Discharge date: _____

Diagnosis: /Extent of disability

Allergies:

Diagnosis known:

To family	To person
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> No

Reason for referral:

Prognosis:

A. Rehabilitation
 B. Maintenance at present
 C. Deterioration likely

Recommended/requested supports:

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: Y _____ N _____
- Do the shopping: Y _____ N _____
- Do the housekeeping: Y _____ N _____
- Arrange own activities: Y _____ N _____

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) _____

Supplies and/or equipment requested: _____

1 AMBULATION

- _____ Unlimited cor s mech. aid
- _____ Outdoors with aid
- _____ Indoors, semi-amb
- _____ Indoors, semi-amb with aid
- _____ Wheelchair independent
- _____ Wheelchair with aid
- _____ Bed to chair
- _____ Bed to chair with aid
- _____ Bedfast – can turn self
- _____ Bedfast – must be turned
- _____ Other

2 CONTINENCE

- _____ Completely continent
- _____ Incontinent urine, occ.
- _____ Incontinent urine, always
- _____ Indwelling catheter
- _____ Incontinent feces, occ.
- _____ Incontinent feces, always
- _____ Colostomy
- _____ Other

3 MENTAL STATUS

- _____ Completely orientated
- _____ Mildly confused, occ.
- _____ Mildly confused, always
- _____ Moderately confused, occ.
- _____ Moderately confused, always
- _____ Markedly confused, occ.
- _____ Markedly confused, always
- _____ Depressed
- _____ Overly anxious
- _____ Bizarre behaviour
- _____ Other

4 PERSONAL CARE ASSISTANCE

Bathing	Dressing	Toileting	Feeding	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- No help needed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- Minimum help
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- Moderate help
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- Complete help

Nature/type of service:

Amount and frequency: