Manitoba Home Care Program

Manitoba
Health and Healthy Living

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
☐ new ☐ resume ☐ reopened	Agency to be billed

Client's name (Surname)	(Given Names)	Sex	Birthdate Day Month Year	Phone number
Home address PO Box No	Street address			Postal code
Band name	Treaty number	Registration no.		Social Insurance No.
Region	Area	Can person communicate in English?	If not, which language?	

Present location: ☐ Same as above address ☐ Hospital ☐ Hostel ☐ Nursing home ☐ Home of relative ☐ Room & board/foster home

☐ 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

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**
☐ Yes	☐ Yes
☐ No	☐ No

Reason for referral:

Prognosis:

☐ A. Rehabilitation

☐ B. Maintenance at present

☐ C. Deterioration likely

Recommended/requested supports:

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

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Discharge medications/treatment:

Diet:

Living arrangement:
_____ Alone
_____ With relatives
_____ With others

Family support:
_____ Not Available
_____ Minimal
_____ Moderage
_____ 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:

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	
				– No help needed
				– Minimum help
				– Moderate help
				– Complete help

Service recommended:	**Nature/type of service:**	**Amount and frequency:**
_____ Nursing		
_____ Therapy ☐ pt ☐ ot		
_____ Home care attendant/orderly		
_____ Homemaking		
_____ Day hospital		
_____ Meal delivery		
_____ Adult day program		
_____ Other (specify)		

Supplies and/or equipment requested: _____