



Personal Attendant Care Inc.

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REFERRAL AND APPLICATION FORM

Please Note: All fields must be completed in full before processed

Date of Application (MM/DD/YY): _____

Surname: _____ First Name: _____

Address: _____

City: _____ Province: _____ M: _____ F: _____

Postal Code: _____ Phone #: _____

Service Address if different from above: _____

Health Card Number: _____ Date of Birth: _____
(MM/DD/YY)

Marital Status: _____ Lives with: _____

Language Spoken: _____ Interpreter required: _____

Identify permanent physical disability (medical diagnosis, condition):

Methods of Communication (verbal, written, gestures):

Skin Integrity (History of open areas, rashes): _____

Chronic Pain: _____

Allergies: _____

Mental Health (Past or present aggression, suicidal tendencies, disorientation, agitation): _____

Recent Hospitalizations / Surgeries: _____

Please check off any that apply:

Transfer Devices Used:

- | | |
|---|--|
| <input type="checkbox"/> Hoyer Lift (manual/electric) | <input type="checkbox"/> Transfer Pole |
| <input type="checkbox"/> Ceiling Track | <input type="checkbox"/> Transfer Board |
| <input type="checkbox"/> Sam Hall Turner | <input type="checkbox"/> N/A – self-transfer |

Equipment Used:

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Wheelchair (manual/electric) | <input type="checkbox"/> Stair Glide |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Scooter |
| <input type="checkbox"/> Cane | |

Impairments:

- Speech
- Vision
- Auditory

- Pets

Specify pets in home: _____

Are the pets known to bite or attack? _____

- Smoker

Is applicant aware smoking not permitted while care is being provided? _____

CE CCAC and Other Referring Agencies Only

Intent for requesting services:

To assume all client services

To compliment current services

Primary Caregiver: _____

Has the client had previous personal or homemaking support services?

Current Services in Place:

Service	Days of the Week	Time/length
Nursing	_____	_____
OT	_____	_____
PT	_____	_____
Speech/Rehab	_____	_____
Personal Support/ Homemaking	_____	_____

Applicant must have a contingency plan in place in case of disturbance to scheduled services? (unsafe weather, no coverage available etc.)

Specify Contingency Plan:

Name: _____ Relationship: _____

Home Phone #: _____ (Alt #): _____

Has permission been given / obtained to release and collect information regarding this referral? Yes No

Authorizing Signature: _____