PAC REFERRAL/APPLICATION FORM

PERSONAL ATTENDANT CARE inc.

Ontario
Central East Local Health Integration Network

Eligibility

Please complete the eligibility requirements before completing the rest of the form.
All fields must be completed in full and all referral/applications will be screened for eligibility.

You have a permanent physical disability?	**Yes**		**No**	
You require personal care (bathing, dressing, toileting etc.)?	**Yes**		**No**	
You are able to direct your own services?	**Yes**		**No**	

Surname:	**First Name:**
Address: **Apt/Unit#:**	**Access to Home:** **Lockbox Code:** **Lifeline:** Yes ☐ No ☐
City/Town: **Province:** **Postal Code:**	**Phone Number:**
Health Card Number: **Version Code:**	**E-mail Address:**
Service Address if different from above (i.e. school/work):	**Date of Birth** (MM/DD/YY):_____ **Female** ☐ Male ☐
Identify permanent physical disability (medical diagnosis, condition):	**Secondary Diagnosis:**
Lives With: **Primary Caregiver:**	**Primary Language:** Interpreter Required Yes **Secondary Language:**
Methods of Communication (verbal, written, gestures):	
Height: **Weight:**	**Allergies:**

Require Support With: ***(Please check off all that apply)***

☐Grooming	☐Dressing/Undressing	☐Shower	☐Sponge Bath
☐Eating/Feeding	☐G-Tube Feed	☐Meal Support	
☐Toileting / Elimination	☐Incontinent Care	☐Medication Cue/Reminder	
☐Condom catheter	☐Indwelling Catheter Care	☐Intermittent Catheter	
☐Bowel - Suppository	☐Bowel - Enema	☐Bowel - Digital Stimulation	
☐Transfers	☐Mechanical Lift	☐ROM / Exercise Program (Established by OT or PT)	

***If assistance required with established bowel/bladder routine, copy of Physician's order will be require**

Service Time Required:

AM ☐ AFTERNOON ☐ PM ☐

Number of visits a week required: _____

Current Services in Place:

Service: _____ Visits per Week: _____ Time/Length of Service: _____

Waitlisted for any of the following: ☐ Long Term Care ☐Supportive Housing ☐Assisted Living

Personal Attendant Care Inc. 1650 Dundas St. E, Suite 200, Whitby, ON L1N 2K8
P: 905-576-5603 Toll Free 1-888-433-0240Fax: 905-576-8020 Email: mail@pacdurham.ca

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Please check off all that apply:

Mood and Behaviour:

☐Verbal Aggression ☐Physical Aggression ☐Suicidal Tendencies ☐Depression

Other: Specify _____

Pain: ☐Chronic ☐Acute Location: _____

Recent Hospitalizations / Surgeries: _____

Falls: ☐Last 30 Days ☐Last 60 Days

Infectious Disease (ARO):

☐MRSA ☐C-Diff ☐VRE ☐Shingles ☐Other: _____

Impairments:

☐Speech	☐Difficult to Understand	☐No Speech	☐Able to Use Telephone
☐Vision	☐Legally Blind	☐Totally Blind	☐Peripheral Vision Only
☐Hearing	☐Hard of Hearing	☐Deaf	☐Wears Hearing Aids
☐Confused	☐Poor Judgement	☐Dementia	☐Memory Deficit

☐Choking Risk ☐Difficulty Chewing (If yes, list precautions): _____

Respiratory: ☐ Oxygen use ☐CPAP/BiPAP ☐Ventilator

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

Transfer Devices Used:

☐ Hoyer Lift (manual/electric)	☐Transfer Pole	☐Sam Hall Turner
☐ Ceiling Track	☐Transfer Board	☐Transfer Belt
☐ N/A – Self Transfer		

Equipment Used:

☐Wheelchair (manual/electric)	☐Scooter	☐Walker
☐Cane	☐Bath Chair	☐Stair Glide

Health and Safety:

☐Pets: List pets in home: _____

Are the pets known to bite or attack? _____

☐Client Smokes ☐Family Smokes (Smoking is not permitted while care is being provided)

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

Contingency Name: _____ Relationship: _____

Phone #: _____

Emergency Contact: _____ Relationship: _____

Phone #: _____

Is the individual aware of this referral/application?	**Y** ☐ **N** ☐
Permission to release / collect information obtained?	**Y** ☐ **N** ☐
Referral Source: **Phone#:**	
Primary Contact (if not contacting individual directly)**:** **Phone#:**	

Please attach your current medication list and return with your completed referral/application.

Authorizing Signature:	**Please Print Name:**	**Date:** (MM/DD/YY)

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