Request for Service/Update of Service

SOURCE OF REFERRAL/UPDATE:

Name	Organization/relationship	Contact phone #

Request/Update Completed By:

APPLICANT INFORMATION:

Last:	First:	Middle Initial:
Applicant Date of Birth: MM DD YY		Male ☐ Female ☐
Height:	Weight:	
SIN #:	ODSP #:	Health Card #:

DIAGNOSIS:

ADDRESS:

Number:	Street:	Unit/Apt. #:
City:	Province:	Postal Code:

CONTACT:

Home phone:	Contact:
Cell phone:	Contact:
E-Mail address:	

EMERGENCY CONTACT:

Relationship to applicant :	
Name:	Phone Number:

FAMILY INFORMATION:

MOTHER:

Surname:	First:	Initial
Address: Street Number:	Street:	Unit/Apt.#
City:	Province:	Postal Code:
Telephone: (Home):	(Cell):	(Work):
E-mail address:		
Date of Birth: MM[ ] DD[ ] YY[ ]	Birthplace:	
Living [ ] Deceased [ ] If so, Date of Death:		

FATHER:

Surname:	First:	Initial
Address: Street Number:	Street:	Unit/Apt.#
City:	Province:	Postal Code:
Telephone: (Home):	(Cell):	(Work):
E-mail address:		
Date of Birth: MM[ ] DD[ ] YY[ ]	Birthplace:	
Living [ ] Deceased [ ] If so, Date of Death:		

SIBLINGS:

SURNAME	FIRST NAME	D.O.B.	TELEPHONE #

ADVOCATE/MAIN CONTACT FOR FAMILY: Caregiver, if different:

FAMILY SUPPORT/INFORMAL SUPPORT:

RESIDENTIAL HISTORY:

Is applicant presently living with the main contact/emergency contact? : ☐YES ☐NO
If Yes- Provide caregiver's name:
If No: Date applicant was admitted into residential placement:
Name of present residential placement:
Other:

PLEASE LIST ALL <u>FORMER</u> RESIDENTIAL SETTINGS:

Name of residential placement	From:	To:

IS THE APPLICANT:

☐ Canadian Citizen	☐ Landed Immigrant	☐ Crown Ward
☐ Other		

IS THERE:

☐ Legal Guardian, Name:
☐ Power of Attorney, Name:

PLEASE PROVIDE AN OUTLINE OF THE CURRENT HOME, LIFE SITUATION AND *WHY* ARE DAY PROGRAM SERVICES NEEDED?

CULTURAL AND/OR RELIGIOUS CONSIDERATIONS:

Does the applicant require any cultural and/or religious considerations?	☐ YES ☐ NO
If yes, please describe:	

COMMUNICATION

What is the primary language spoken/understood by the applicant?		
Do either of the parents	Understand English	☐ YES ☐ NO
	Speak English	☐ YES ☐ NO

How does the applicant communicate?

Verbal Communication: ☐ Yes ☐ No

Please describe:

_____

<u>Use of adapted communication system</u>:

Sign Language Communication ☐ Yes ☐ No
PECS- Picture Exchange Communication System ☐ Yes ☐ No
Keyboarding ☐ Yes ☐ No
Assistive Technology & Augmentative Communication Devices/Systems ☐ Yes ☐ No
Please Describe:

HISTORY OF SUPPORTS SERVICES INVOLVED:

PLEASE PLACE A CHECK MARK IF CURRENTLY INVOLVED OR INDICATE HISTORY OF INVOLVEMENT IF NO LONGER INVOLVED

MCSS Funding:	*School History:*
SSAH ☐ _____/year ACSD ☐ _____/month ODSP ☐_____/month	Current /last school:_____ Graduation Year: _____ Program Type: Self-Contained ☐
MOH Services:	Other:
CCAC ☐ Support and Hours:_____ March of Dimes ☐ Support and Hours:_____ LTC ☐	

MCSS (Ministry of Social Service) MHO (Ministry of Health and Long-Term Care) SSAH (Support Services at Home), ODSP (Ontario Disability Program), CCAC (Community Care Access Centre), March of Dimes, LTC (Long Term Care)

PLEASE LIST <u>CURRENT</u> AGENCIES INVOLVED IN*:*

AGENCY/PROGRAM	LENGTH OF TIME (Since)	CONTACT PERSON	TELEPHONE #
Why the applicant is looking to combine two or more day programs?			

Do you authorize alternatives to contact the agencies/programs above to obtain a reference on the applicant's personality, skills levels and behaviour?

☐YES ☐NO

PLEASE LIST <u>PAST</u> INVOLVEMENT WITH OTHER AGENCIES/PROGRAMS:

AGENCY/PROGRAM	LENGTH OF TIME FROM - TO	CONTACT PERSON	TELEPHONE #
Why the applicant left this organization?			

Do you authorize alternatives to contact the agencies/programs above to obtain a reference on the applicant's personality, skills levels and behaviour?

☐YES ☐NO

MEDICAL HISTORY:

Allergies:	☐ NO ☐ YES - If YES, please list & describe reaction:
Epilepsy:	☐ NO ☐ YES - If YES, please describe:
Seizures:	☐ NO ☐ YES – please describe, triggers, how often, condition after seizure
Sleeping difficulty:	☐ NO ☐ YES- If Yes, please describe:
Dietary Issues:	☐ NO ☐ YES- If Yes, please describe:
Menstrual Cycle:	☐ NO ☐YES- If YES, health intervention required:

Hearing Problems: Any current or chronic ear infections? ☐ NO ☐ YES If Yes, please describe:
Vision Problems: ☐ NO ☐ YES - Wear glasses? What is the condition?
Diabetes: ☐ NO ☐ YES - please list intervention/modification
Sore Throats ☐ NO ☐ YES - please list intervention/modification
Asthma: ☐ NO ☐ YES - please list intervention/modification
Blood Pressure: ☐ NO ☐ YES - please list intervention/modification
Heart Conditions: ☐ NO ☐ YES - please list intervention/modification
Arthritis: ☐ NO ☐ YES - please list intervention/modification
Varicose: ☐ NO ☐ YES - please list intervention/modification
Chronic Back pain: ☐ NO ☐ YES - please list intervention/modification
Nose bleeds: ☐ NO ☐ YES - please list intervention/modification Any other type of bleeds or Hemophilia? ☐ NO ☐ YES - please list intervention/modification
Oral Care: Toothaches ☐ NO ☐ YES - please list intervention/modification Gum Problems ☐ NO ☐ YES - please list intervention/modification

HEALTH HISTORY:

Date	List any illnesses, hospitalizations, surgeries & x-rays	Reasons

MEDICATIONS:

Does the applicant take medications at home: ☐ NO ☐ YES

NAME OF MEDICATION	PURPOSE	DOSAGE	ADMINISTRATION TIME AND WAY OF TAKING MEDICATION (i.e., with yogurt, crushed, etc., criterion to administer PRN medication)

Does the applicant need to take any medications at Day Program: ☐ NO ☐ YES

If yes, describe:

Are there any concerns regarding any of the above medication? ☐ NO ☐ YES

If yes, describe:

IMMUNIZATIONS:

DPTP diphtheria, pertussis, tetanus and polio). Date Given:	MMR (measles, mumps and rubella) Date Given:
HIB (meningitis) Date Given:	Measles Booster Date Given:
D&T(diphtheria & tetanus) Date Given:	Hepatitis B Date Given:
Polio Booster Date Given:	BCG (tuberculosis serum) Date Given:

SCREENING:

(Tuberculosis skin test) Date read:	Result:
Last Hepatitis Screen:	Result:

GENITOURINARY

Does the applicant have any urinary issues or Urinary incontinence? ☐ NO ☐ YES If yes, describe:
Requires Diapers? ☐ NO ☐ YES If yes, describe: Does applicant needs Catheter (by self/others) ☐ NO ☐ YES
Menstrual Period (regular, painful) ☐ NO ☐ YES If yes, describe what do you do to control pain or situation:

MEDICAL PRACTITIONERS:

FAMILY PHYSICIAN:	Telephone:
Address:	Postal Code:

DENTIST:	Telephone:
Address:	Postal Code:

SPECIALIST: Type:	Telephone:
Address:	Postal Code:

SPECIALIST: Type:	Telephone:
Address:	Postal Code:

MENTAL AND BEHAVIOURAL SUPPORTS SERVICES:

Does the individual exhibit any co-existing problems? Psychiatric: ☐ NO ☐ YES - If YES, please describe:
Physical: ☐ NO ☐ YES - If YES, please describe:

Does the applicant display any behavioural problems? ☐ NO ☐ YES If YES, please describe difficulties		
☐Verbal	☐Self-Injury	☐Sexual Aggression
☐Property Destruction	☐Emotional outbursts	☐Physical Aggression
☐Stealing	☐Non-Compliance	☐Disobedient
☐Violent	☐Other, please describe:	

PSYCHOLOGICAL, PSYCHIATRIC or EDUCATIONAL ASSESSMENT HISTORY:

TYPE	DATE	SERVICE/AGENCY INVOLVED	CONTACT APPLICANT	ASSESSMENT AVAILABLE YES/NO/IN PROGRESS

SUPPORT NEEDS AND SKILLS ASSESSMENT

Can the applicant be left unattended in the home during the day? ☐Yes ☐ No
If Yes, how long?

Can the applicant be left unattended in the home overnight? ☐Yes ☐ No

Does the individual have any past or present involvement with the justice system? ☐ Yes ☐ No Explain:

APPLICANT PERSONAL CARE	Direct Support	Hand over Hand	Prompts and Reminders	No Assistance Required
Toileting				
Bathes/Showers				
Washes Hair				
Brushes Teeth				
Grooming (shaves/hair care)				
Nails				
Menstrual Care				
Chooses Clothing				
Dresses One self				
Undresses One self				

SOCIAL AND COMMUNITY	Direct Support	Shadowing/learning with support)	Prompts/ Reminders	No Assistance Required
Communicating basic needs and wants				
Request support/assistance/help				
Having a conversation				
Initiates Access to Community				
Call/schedule appointments				
Interacting in groups of 5 or 10 people				
Follows simple directions				
Travel using public transit				
Participating in activities				
Time management				
Social skills in community				
Safety skills in community				

LIFE AND WORKING SKILLS	**Direct Support**	**Shadowing/learning with support)**	**Prompts/ Reminders**	**No Assistance Required**
Support for safety in home				
Support for safety in the community				
Support for evacuate during an emergency				
Use of Simple First Aid skills				
Avoiding Health hazards				
Maintaining Physical Health				
Sexual Health				
Regulating Emotional Control				
Aware of phone #/Address				
Problem Solving Skills				
Financial Management				
Managing Money				
Keeping money and personal items safe				
Nutrition Awareness				
Dietary Decisions				
Maintain Food Safely				
Supports for Food Preparation				
Supports for Eating and Drinking				
Personal Information: Name, BD, Address, Phone#				
Administrating Medication				
Securing Medication				
Taking medication				
Time Orientation				
Reading and Writing Skills				
Assistance with Mobility				
Household chores				
Laundry				
Holding/Grasping things				

PHYSICAL ACTIVITY GUIDELINES:	20 minutes	30 minutes	60 minutes	90 minutes
Individual can sit for				
Individual can stand for				
Individual can walk for				

Individual can lift	2 pounds	5 pounds	10 pounds	15 pounds

Individual can safely perform the following physical movements?

Walking up and down stairs ☐ Yes ☐ No

Reaching over head ☐ Yes ☐ No

Twisting at the waist ☐ Yes ☐ No

Bending at the waist ☐ Yes ☐ No

Working with hands ☐ Yes ☐ No

FUTURE PLANNING:

Please describe, the optimal setting and supports for the applicant for the requested services. Please include optimal timelines for this service to be available to the applicant:

Thank-you, we will contact you to arrange an assessment should your application be approved.