



10 BELL LANE, P. O. BOX 2048 BRANTFORD, ONTARIO N3T 5W5

APPLICATION FOR SERVICES

Type of Service requested (can be more than one)

	Supportive Housing (10 Bell Lane)
	Supportive Housing (255 Colborne Street)
	Attendant Care Outreach
	Respite (Aging at Home)
	Assisted Living and Community Collaborative (must be referred through CCSA (PSW) through HPG)
	Transitional Care (must be referred from CCAC Hospital Coordinator)

Urgency of need of service:

	Crisis – within the next 2-3 days
	Urgent – within the next month
	Immediate – within 6 months
	Non-Urgent – 6 months or more

Date of Application:	
Applicant's Name:	
Address:	
Date of Birth:	
Male / Female (circle)	Marital Status:
Source of Income:	
Health Card Number:	ODSP:
Clinical diagnosis/reason for referral (if known):	

Current Placement if not at above address:	
Telephone No:	
Date of Birth:	
Contact Person:	
Relationship:	
Address:	
Telephone #:	Email Address:

Referral Information:	
Name of person referring:	
Agency:	
Contact - Phone:	Email:
Date of last RAI assessment (if known):	



PARTICIPATION HOUSE BRANTFORD

RELEASE OF INFORMATION

I hereby grant permission to the Executive Director of **PARTICIPATION HOUSE BRANTFORD** to obtain/give information from/to any social/medical/educational authorities for program or medical needs for the undersigned resident.

(NAME)

(WITNESS)

(DATE)



CLIENT PROFILE SHEET

Name:	DOB:
Home Address:	Postal Code:
	Phone:

Referral Source: Hospital CCAC other _____

Contact Person: _____

Attachments : Rai -hc Care Plan other _____

Emergency/Family Contact: _____

Reason for Stay/ Goal: _____

Discharge Destination: _____

CCAC Referral Initiated: Yes, for: _____ n/a

Medical Information

H.C.	
Physician:	Phone:

Diagnosis: _____

Allergies: _____

Medication & Treatment Orders : (attach orders and copy of MARS)

Pharmacy: _____ **Phone:** _____

ODSP? Y N # _____

Other Allied Health Professionals Involved: _____

Agency/Provider : _____ **Phone:** _____

Care Plan to be completed on reverse

Details / Description of Care Requirements

Mobility <input type="checkbox"/> ambulatory <input type="checkbox"/> wheelchair	
Transfer <input type="checkbox"/> independent <input type="checkbox"/> transfer assist <input type="checkbox"/> lift	
Diet <input type="checkbox"/> independent eating <input type="checkbox"/> must be fed	
Elimination <input type="checkbox"/> continent <input type="checkbox"/> incontinent	
Oral Care <input type="checkbox"/> natural teeth <input type="checkbox"/> dentures	
Skin Care/condition <input type="checkbox"/> skin breakdown? <input type="checkbox"/> history of breakdown	
Other:	
Other:	
<p align="center">Complete Upon Admission:</p> <p>Date of Admission: _____ Room: _____</p> <p>Anticipated Length of Stay: _____</p> <p>Admitted By: _____</p>	