Short Term Home Support Services Referral

☐ Hospital Discharge ☐ End of Life CRMS #_____

Name: _____ Diagnosis: _____

Address: _____ Pertinent History: _____

_____ Allergies: _____

Telephone #: _____ Family Physician: _____

DOB:_____ HCN:_____ Telephone #: _____

Next of Kin: _____ Relationship _____ ☐ Lives Alone ☐ Lives With: _____

Address: _____Tel # _____ Pets in the home Yes ☐ No ☐ Smoking in the home Yes ☐ No ☐

Personal Care *(X indicates supplies/equipment already in place)*	**Self-Care**	**Assist Care**	**Total Care**
Grooming/Dressing			
Bathing ___ Bath Chair/Bench			
Toileting ___ Catheter ___ Attends/Pull ups ___ Raised Toilet Seat ___ Commode			
Turn/Transfer __ Transfer Board __Lift __ Hospital Bed			
Ambulation ____ Wheelchair ___ Walker ____ Cane			
Equipment Needed			

Supportive Care	**Yes**	**No**
Meal Preparation Dietary Considerations:		
Light Housekeeping		
Respite for Family		
Behavior or Cognition Altered Specify:		
Delegated Function Required Specify:		
Medication Administration ☐ Self ☐ Family ☐ Nurse ☐HSW		

☐ Risk for Falls ☐ Risk for Pressure Ulcers

Comments: _____

_____

For office use only:

	Hours/day	Days/week
Personal Care		
Household Management (Meals & Light Housekeeping)		
Respite		
TOTAL HOURS		

Agency: _____

Date Service to start: _____

Preferred Time: _____

Send Invoice to: Finance Office Central Health 3 Bell Place Gander, NL A1V 2T4	Date Services Begin:	Total Hours Approved:
	End/Review Date:	Approved By: Telephone #::
	Case Manager: Tel #	Date: