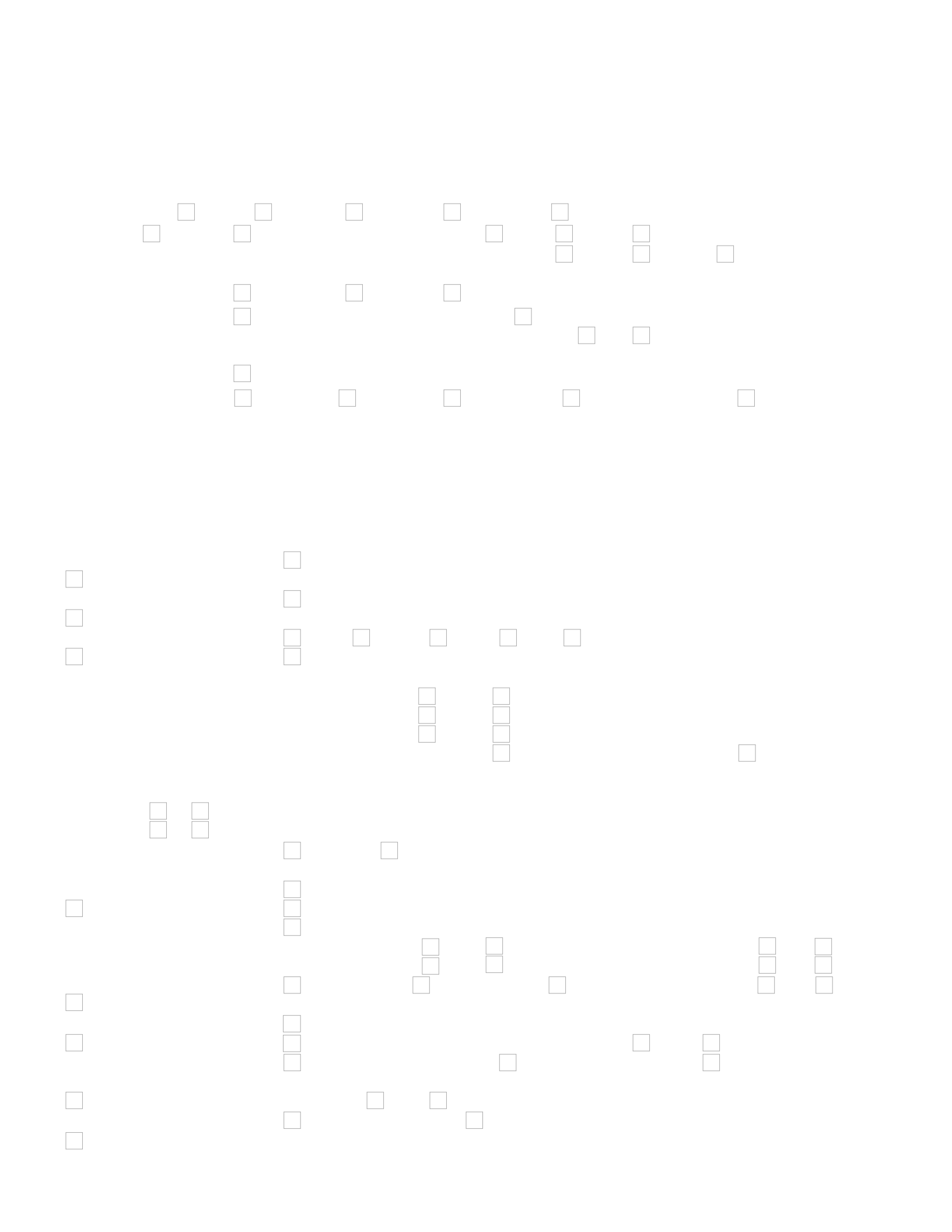

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E

Surname:	First Name:
C + 5 , 6 #:	Date of Birth (DD/MM/YYYY):
HCN:	Version Code

Behavior Symptoms: ☐ No concerns	☐ Wandering ☐ Verbal Abuse ☐ Physical Abuse ☐ Socially inappropriate
Nutrition: ☐ No concerns	☐ Restricted intake placing patient at imminent risk of dehydration and/or malnutrition ☐ Restricted intake placing patient at potential risk of dehydration and/or malnutrition ☐ Patient requires an assessment for p texture Affected intake: ☐ Solids ☐ Fluids ☐ Both ☐ Special Diet ☐ Nutritional Supplement Food Intake ☐ Adequate ☐ Inadequate Food Texture: Date Recommended(DD/MM/YYYY): Fluid Intake: ☐ Adequate ☐ Inadequate Fluid Texture: Date Recommended(DD/MM/YYYY): Weight loss of 5% or more in last month: ☐ No ☐ Yes
Swallowing (SLP Only): ☐	☐ New or worsening signs of swallowing problems placing person at imminent risk of aspiration/ recurring pneumonia or airway obstruction ☐ Worsening /chronic signs of swallowing problems placing person at potential risk of aspiration/ recurring pneumonia or airway obstruction *(coughing/coughing, ... d of food/fluids in mouth, throat-clearing/wet-sounding voice when eating/drinking or ☐ shortly after, ☐ audible congestion*
Mobility Devices: **(for OT referrals only)**	Current equipment: ☐ None ☐ Cane ☐ Walker ☐ Geri chair ☐ Wheelchair (Type:) ☐ Owned by patient ☐ Loaned by facility ☐ Rented through vendor: ☐ Equipment in place no longer meet's patients' needs due to changes in patient's condition. Issues present such as: ☐ Sliding ☐ Leaning/slouching ☐ Pressure injury ☐ Poor fit (weight gain/loss) ☐ Wheelchair/cushion in place needs replacement due to wear.
Continence: **(for OT referrals only)**	Bladder: ☐ Full Control ☐ Incontinent ☐ Ostomy ☐ Catheter Bowel: ☐ Full Control ☐ Incontinent ☐ Ostomy
Skin Condition **(for OT referrals only):** ☐ **No concerns**	☐ Pressure injury (ulcer) on weight bearing surface Describe:
Primary Contact (MANDATORY):	☐ Patient ☐ SDM (e.g. Spouse, Child, POA Personal Care, Public Guardian and Trustee)
Substitute Decision Maker ☐ **Not applicable**	Name: Relationship: Address: Postal Code: Phone #: Preferred Language: ☐ English ☐ French ☐ Other:
Power of Attorney for Personal Care ☐ Not Applicable	Completed: ☐ Yes ☐ No Enacted: ☐ Yes ☐ No ☐ Copy to ,/E Name: Relationship: Phone #: Preferred Language: ☐ English ☐ French ☐ Other:
Power of Attorney for Finances ☐ Not Applicable	Completed: ☐ Yes ☐ No Enacted: ☐ Yes ☐ No ☐ Copy to ,/E Name: Relationship: Address: Postal Code: Phone #: Preferred Language: ☐ English ☐ French ☐ Other:

Completed by (Name): **Date (DD/MM/YYYY):**

Ontario

HOME AND COMMUNITY CARE SUPPORT SERVICES
North East

Surname:	First Name:
CHRIS #:	Date of Birth (DD/MM/YYYY):
HCN:	Version Code

REFERRAL FROM LONG-TERM CARE HOME FOR THERAPY SERVICES

Income	☐ ODSP ☐ OAS ☐ CPP ☐ Private Pension ☐ Other:
Private Insurance	☐ Veterans Affairs Canada ☐ WSIB ☐ Non-insured health benefits for First Nation's resident

Print name: **Phone #:**

Signature (MANDATORY): **Date** (DD/MM/YYYY):

☐ **KIRKLAND LAKE**	☐ **NORTH BAY**	☐ **PARRY SOUND**	☐ **SAULT STE. MARIE**	☐ **SUDBURY**	☐ **TIMMINS**
Tel: 705 567 2222 888 602 2222	Tel: 705 476 2222 888 533 2222	Tel: 1-800 440 6762	Tel: 705 949 1650 800 668 7705	Tel: 705 522 3461 800 461 2919	Tel: 705 267 7766 888 668 2222
Fax:705 567 9407	Fax: 705 474 0080	Fax: 1-855 773 4056	Fax: 705 949 1663	Fax: 705 522-3855	Fax: 705 267 7795