

Participation Lodge & Community Services

APPLICATION FOR SERVICE

Program Applied For:

- Acquired Brain Injury Program
 Residential Program
 Hanover Apartment
 Owen Sound Apartment
 Outreach

Name of Applicant

Gender

Birth date

			M	F	/ /
Surname	First name	Preferred			Day / Month / Year

CURRENT ADDRESS

Agency / Organization
(if applicable)

Address:	House #: Street:			
	City: Province: Postal Code:			Home Phone #:
				County

PRIMARY CONTACT

Contact Name		Relationship to Client:		
Address:	House #: Street:			
	City: Province: Postal Code:			Home Phone #:
				Work Phone #:

Section A.

DEMOGRAPHIC INFORMATION

Residential History: (list the places client has lived starting with most recent)

Place	Dates (from-to)	Reason for Leaving

EDUCATIONAL HISTORY:

Highest Grade Completed

Marital Status:

- Never married
 Divorced/ Separated
 Married

SOURCE OF INCOME:

- ODSP
 CPP
 Self / family
 Insurance/ third party funding
 WSIB
 Unemployment insurance
 Other:

OCCUPATION:

Section B.		MEDICAL INFORMATION AND HISTORY		
Health Card Number		Drug Card Number		
Physician:		Phone #:		
Physician's Hospital		Phone # of Hospital:		
Pharmacy Used:		Phone # of Pharmacy		
ALLERGIES List all food, drugs, latex, environmental allergies				
Allergy	Reaction	Intervention required		
Continue on back of sheet if more space required				
DIAGNOSIS			Year of Diagnosis	
Primary Diagnosis:				
Secondary Diagnosis (s):				
Weight:	lbs.	Height:		
Does Client smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does Client use "street" drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is client permitted alcohol?	
PHYSICAL HEALTH: Do you experience any of the following (Please indicate on back of page how these are managed.)				
Endocrine/metabolic/ Nutritional <input type="checkbox"/> Diabetes <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Bulimia <input type="checkbox"/> Anorexia <input type="checkbox"/> constipation <input type="checkbox"/> Stomach problems <input type="checkbox"/> Menstrual disorder <input type="checkbox"/> Liver Disease <input type="checkbox"/> Chronic diarrhea <input type="checkbox"/> Kidney disease Heart/ Circulation <input type="checkbox"/> Heart disease <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Deep vein thrombosis <input type="checkbox"/> Hypertension <input type="checkbox"/> Hypotension <input type="checkbox"/> Peripheral edema	Musculoskeletal <input type="checkbox"/> Arthritis <input type="checkbox"/> Missing limb/ amputation <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pathological bone fracture <input type="checkbox"/> Spinal Muscular Atrophy <input type="checkbox"/> Spinal Cord injury <input type="checkbox"/> ALS <input type="checkbox"/> joint inflammation Psychiatric/Mood <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar <input type="checkbox"/> Schizophrenia <input type="checkbox"/> delusions <input type="checkbox"/> obsessive compulsive	Sensory <input type="checkbox"/> Cataracts <input type="checkbox"/> Diabetic retinopathy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular degeneration Neurological <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Stroke <input type="checkbox"/> Aphasia <input type="checkbox"/> Hemiplegia/ hemiparesis <input type="checkbox"/> Paraplegia <input type="checkbox"/> Quadriplegia <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Vertigo <input type="checkbox"/> pica <input type="checkbox"/> multiple sclerosis <input type="checkbox"/> muscular dystrophy	<input type="checkbox"/> Headaches <input type="checkbox"/> Tourettes <input type="checkbox"/> ADD/ ADHD <input type="checkbox"/> Autism <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Downs Syndrome <input type="checkbox"/> Developmental delay Other <input type="checkbox"/> Anemia <input type="checkbox"/> Cancer <input type="checkbox"/> Renal failure <input type="checkbox"/> Weight loss/gain <input type="checkbox"/> Insomnia <input type="checkbox"/> Night mares <input type="checkbox"/> Drug abuse <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Shingles: <input type="checkbox"/> Rashes/ skin disorders <input type="checkbox"/> Bleeding disorder	Infections <input type="checkbox"/> Antibiotic Resistant <input type="checkbox"/> Infection (MRSA) <input type="checkbox"/> Clostridium difficile <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Aids/ HIV <input type="checkbox"/> Pneumonia <input type="checkbox"/> Septicemia <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Urinary tract inf <input type="checkbox"/> Hepatitis <input type="checkbox"/> Immune Disorders Pulmonary <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema/COPD <input type="checkbox"/> Shortness of breath Apnea <input type="checkbox"/> Tracheotomy <input type="checkbox"/> oxygen use <input type="checkbox"/> Ventilator

IMMUNIZATIONS

If status is unknown you may be required to be re-immunized.	CURRENT?				CURRENT?			Have you had any of these illnesses?
	Yes	No	Not sure		Yes	No	Not Sure	
Pertussis				Rubella (German measles)				
Diphtheria				TB skin test				
Tetanus				Chicken pox				
Polio				Hepatitis A				
Measles				Hepatitis B				
Mumps				Flu Shot				
Pneumovax				ATTACH COPY OF IMMUNIZATION RECORD				

ACQUIRED BRAIN INJURY CLIENTS

Date of Injury:	Cause of Brain injury: (mva, anoxia, etc)
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Rancho Los Amigos Score: (circle appropriate level) 1 2 3 4 5 6 7 8	Was client in coma? <input type="checkbox"/> Yes <input type="checkbox"/> No Length of coma: _____
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Hospitalization Information:	Name of facility	How long?
Acute Care hospital		
Rehabilitation		
Long term care		

Are you currently receiving rehabilitation services? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explain
Are you currently receiving other support services? <input type="checkbox"/> Yes <input type="checkbox"/> No	

***COMPLETE THE ABI CHECKLIST ATTACHED**

SEIZURES:	Is Client subject to seizures?	
	Yes	No
Describe a typical seizure	<input type="checkbox"/>	<input type="checkbox"/>
	How often does Client have seizures?	How long does seizure usually last?
Movement		
Interventions required during / after seizure:		
Expected behavior before and after		

MEDICINE NAMES		Dosage	Times Taken	Reason Why Client Takes This Medicine
PRESCRIBED BY PHYSICIAN				
Non-prescription				
TREATMENTS	What	When	Where	Why
Does have any problems with medications?		How does Client take medications?		

Activities of Daily Living

DIET & EATING HABITS

Diet:	<input type="checkbox"/> Regular <input type="checkbox"/> Vegetarian <input type="checkbox"/> Soft <input type="checkbox"/> Pureed <input type="checkbox"/> Cut into bite size pieces <input type="checkbox"/> Straw <input type="checkbox"/> Special utensils other:
Type of diet	
Disorders	<input type="checkbox"/> Diabetes <input type="checkbox"/> Anorexia <input type="checkbox"/> Bulimia <input type="checkbox"/> Prader Willi <input type="checkbox"/> Other
Eating habits	<input type="checkbox"/> Hearty <input type="checkbox"/> Average <input type="checkbox"/> Fussy/Poor
Difficulties	<input type="checkbox"/> Swallowing <input type="checkbox"/> Chewing <input type="checkbox"/> Drinking <input type="checkbox"/> No difficulties
Yes <input type="checkbox"/> No <input type="checkbox"/>	Does client frequently get pale or sweaty, gag or choke during feeding?
Yes <input type="checkbox"/> No <input type="checkbox"/>	Dietary restrictions? explain

Does Client have a G-tube J-tube gravity push pump

Times						
Formula						
Amount						
Water						
Run in over min						

Yes <input type="checkbox"/> No <input type="checkbox"/>	Does Client take anything by mouth? Explain
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Further eating instructions:

SLEEP

Yes <input type="checkbox"/> No <input type="checkbox"/>	Bed rails required?
Yes <input type="checkbox"/> No <input type="checkbox"/>	Does Client require turning at night? Number of times: _____
Yes <input type="checkbox"/> No <input type="checkbox"/>	Sleep difficulties? Explain:
Bed time:	Wake up:

Speech: clear/distinct unclear no speech

Making Self understood:
 Understood easily
 Has some difficulty but can make self understood
 Ability is limited to making concrete requests
 Rarely/never understood

Communication Methods: Words Technical aid
 Communication board sign language

ORAL / DENTAL STATUS

Has dentures or removable bridge
 Some / all natural teeth lost (no dentures)
 Broken, loose or carious teeth
 Inflamed gums, swollen bleeding gums,
 Pockets /Holds food in mouth
 Swallowing problems
 Chewing problems

Vision

- Adequate (see fine detail, including regular print)
 - Slight impairment
 - Moderate impairment
 - Side vision problems(difficulty traveling, bumps into people / objects etc)
 - No vision or see only light,colors or shapes
- Glasses white cane

Hearing

- Hears adequately
 - Minimal difficulty
 - Difficulty in hearing in noisy environments
 - Highly impaired / absence of useful hearing
- Hearing aid lip reading sign language

BEHAVIOR AND SOCIAL SKILLS

All **AQUIRED BRAIN INJURY** CLIENTS
Are required to complete
SECTION B
THE ABI CHECK LIST.

All other clients complete section A below.

If further information is required other clients may also be asked to complete ABI checklist as well.

A.	BEHAVIOR Check of f all behaviors exhibited	Frequency Exhibited	A.	BEHAVIOR Check off all behaviors exhibited	Frequency Exhibited
	No unusual behavior			Repetitive sounds, disruptive sounds,	
	Obsessive compulsive behaviors			screaming,	
	Stealing, rummaging			sexual behavior,	
	Wanders, runs away			disrobing in public	
	Withdrawn/ shy			Smearing food/ feces	
	Depressed, crying, tearfulness			self-abusive acts	
	Exaggeration of physical or other problems to seek attention			Temper tantrums	
	Attention seeking behaviors / Demanding			Verbally aggressive	
	Resistive to care(ADL's, meds, food)			Persistent anger with self or others	
	Repetitive questioning			Physically aggressive towards others	
	Expressions of what appear to be unrealistic fears			Fixates on others, obsessively	
	OTHER: (list)				

BEHAVIORS / SOCIAL SKILLS (to be completed by all clients)

Describe in detail - Severity, cause and early warning signs of behaviors indicated in Sections A or B.

What is the typical intervention in these instances?

Have there been any behavioral changes in the last year? No Yes (explain)

Is the client on Medications that controls or alters behavior?

Yes No

Is a Behavior Management Program used?

No Yes (Please outline in detail on separate page)

BEHAVIORS AND SOCIAL SKILLS

Does the Client most enjoy spending time :

- Alone
- In Groups
- Both

Choose one of the options below to best describe social interaction

- No difficulties functioning in group/ social situations
- Does not do well in group/ social situations
- Requires complete supervision within social situations
- May need prompting and encouragement when getting involved in new experiences

Choose one of the options below to describe decision making skills:

- Independent (no assistance necessary)
- Some difficulty in new situations
- Decisions poor, cues/ supervision required
- Needs total assistance (never/rarely makes decisions)

Sexuality: Please comment on any concerns regarding sexual issues

Does client have any significant fears?

SAFETY

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Is client able to be left unattended for extended periods of time	<input type="checkbox"/>	<input type="checkbox"/>	Can client be left alone when smoking
		How frequently does client need to be checked on:	<input type="checkbox"/>	<input type="checkbox"/>	Is client at risk for falls
		a) during waking hours: every_____	<input type="checkbox"/>	<input type="checkbox"/>	Bed rails
		b) during sleeping hours: every_____	<input type="checkbox"/>	<input type="checkbox"/>	Restraint used
<input type="checkbox"/>	<input type="checkbox"/>	Does client require constant 24 hour supervision	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal behavior/ self injurious behavior
<input type="checkbox"/>	<input type="checkbox"/>	Is client an elopement risk, wanders etc	<input type="checkbox"/>	<input type="checkbox"/>	At risk for exploitation ,easily manipulated and inappropriately persuaded by others In areas of financial, and sexual matters

ACTIVITY PURSUITS

Cycle of Daily events	Involvement Patterns	Interests
<input type="checkbox"/> Stays up late at night	<input type="checkbox"/> Daily contact with relatives/close friends	<input type="checkbox"/> Cards/ other games
<input type="checkbox"/> Naps regularly during day	<input type="checkbox"/> Usually attends church, temple, etc	<input type="checkbox"/> Crafts / arts
<input type="checkbox"/> Goes out 1+ days a week	<input type="checkbox"/> Involved in group activities	<input type="checkbox"/> Exercise/ sports
<input type="checkbox"/> Stays busy with hobbies, reading or fixed daily routine	<input type="checkbox"/> Prefers to spend time alone	<input type="checkbox"/> Music
<input type="checkbox"/> Spends most of time alone or watching TV	<input type="checkbox"/> Actively participates	<input type="checkbox"/> Reading/ writing
<input type="checkbox"/> In bed clothes most of day	<input type="checkbox"/> Participates with encouragement	<input type="checkbox"/> Spiritual/ religious activities
		<input type="checkbox"/> Trips/shopping
		<input type="checkbox"/> Outdoors
		<input type="checkbox"/> TV/ movies
		<input type="checkbox"/> Swimming

LIST ALL OTHER ACTIVITIES WHICH CLIENT LIKES TO PARTICIPATES IN

D. SPECIAL TREATMENTS AND PROCEDURES

SKIN CARE

List All skin conditions (rashes, boils, acne, bruising ,lesions, etc)

ULCERS/ WOUNDS

Is client prone to skin ulcers/ wounds? Yes No

Pressure Ulcers Stasis Ulcers _____

Frequency of Occurrence: _____

SKIN TREATMENTS

- Pressure relieving device for chair
- Pressure relieving device for bed
- Turning/ positioning program
- Nutrition or hydration interventions to manage skin problems
- Sterile dressings
- Application of ointments/ medications

FOOT CARE

Client has one or more of the following:

- Corns, calluses, bunions, hammer toes, overlapping toes, structural problems
- Infection of the foot (athlete's foot, Cellulitis, etc)
- Open lesions on foot
- Requires advance foot care (chiroprapist, podiatrist etc)
- Special shoes, inserts, pads, toe separators

SPECIALIZED TREATMENTS AND PROGRAMS

- | | |
|--|---|
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Speech/ language therapy |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Occupational therapy |
| <input type="checkbox"/> Ostomy care | <input type="checkbox"/> Physical therapy (ROM etc) |
| <input type="checkbox"/> Suctioning | <input type="checkbox"/> Respiratory therapy |
| <input type="checkbox"/> Tracheostomy | <input type="checkbox"/> Psychological therapy |
| <input type="checkbox"/> Oxygen therapy | <input type="checkbox"/> |
| <input type="checkbox"/> Nebulizer treatments | <input type="checkbox"/> |
| <input type="checkbox"/> Ventilator / respirator | |
| <input type="checkbox"/> Apnea monitor | |

PAIN

- | Pain Site | Frequency | Intensity |
|---------------------------------------|---|--|
| <input type="checkbox"/> Back pain | <input type="checkbox"/> No pain | <input type="checkbox"/> Mild pain |
| <input type="checkbox"/> Bone pain | <input type="checkbox"/> Pain less than daily | <input type="checkbox"/> Moderate pain |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Pain daily | <input type="checkbox"/> Times when pain is horrible or excruciating |
| <input type="checkbox"/> Chest pain | | |
| <input type="checkbox"/> Hip pain | | |
| <input type="checkbox"/> Headaches | | |
| <input type="checkbox"/> Stomach pain | | |
| <input type="checkbox"/> Muscle pain | | |
| <input type="checkbox"/> Other: | | |

SPLINTS AND PROSTHESIS

Type of splint / prosthesis	Where worn	When worn

STABILITY OF CONDITIONS

- Stable
- Conditions/ diseases make client's cognitive , ADL, mood or behavior patterns unstable (fluctuating, or deteriorating)
- Client experiencing end stage disease (explain)

PUBLICITY:

May we use photo's or video's of you to promote Participation Lodge & Community Services? Yes No

ASSISTANCE NEEDED

PLEASE INDICATE THE LEVEL OF CARE REQUIRED FOR EACH ACTIVITY

ACTIVITY	I Independence	R reminders only	V verbal prompting	H hand over hand assistance	F full assistance	Time required in min to complete task	Explain support required
ROM, physio programs							
Dressing lower body/upper body							
Eating							
Bowel movements							
Urinating							
Brushing teeth							
Washing hands/face							
Shaving							
Showering/bathing							
Menstrual hygiene							
Administration of medications							
Ordering medications							
Housekeeping							
Laundry							
Menu planning							
Meal preparation							
Grocery shopping							
Finances							
Medical appointments							

Does client have a Power of Attorney for Personal Care? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does Client have Power of Attorney for Finance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name:		Name:	
Phone #:		Phone #:	
Address:		Address:	
Does Client utilize Public Guardian and Trustee? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name:	
		Phone #:	
I confirm that all information provided is accurate and complete to the best of my knowledge.			
Name of Person completing Application	First (PRINT)	Last	Relationship to Applicant
Signature of Person completing application			Date
Signature of Applicant			Date
Signature of Substitute Decision Maker			Date

To be completed by Admission Committee From Participation Lodge & Community Services		
Date Application Rec'd	Program Applied For: <input type="checkbox"/> ABI <input type="checkbox"/> Outreach <input type="checkbox"/> Hanover Apt <input type="checkbox"/> Owen Sound Apt	Placement offered:
Date Reviewed by Admissions & Discharge Committee	<input type="checkbox"/> Residential # of hours of service required _____ per <input type="radio"/> day <input type="radio"/> week	Program Offered: <input type="radio"/> ABI <input type="radio"/> Outreach <input type="radio"/> Hanover Apt <input type="radio"/> Owen Sound Apt <input type="radio"/> Residential
	Meets Eligibility for applied for program? <input type="radio"/> Yes <input type="radio"/> No	Date offered: <input type="radio"/> Accepted <input type="radio"/> Declined
Person reviewing application	<input type="radio"/> Letter of regret sent Date: _____	<input type="radio"/> Release of information obtained
	<input type="radio"/> Placed on Waiting list Date _____ <input type="radio"/> Letter sent confirming acceptance to waiting list Date: _____	<input type="radio"/> Service Agreement completed and signed <input type="radio"/> Service Plan completed

PLEASE LIST NAMES AND PHONE NUMBERS OF THE VARIOUS PROFESSIONAL SERVICES

	Name	Address	Phone Number
FAMILY PHYSICIAN General Practioner			
PHYSICIAN: Specialist			
Psychologist			
Psychiatrist			
Behavior Management			
Pharmacy:			
Dentist:			
Optometrist			
Social Worker			
Adult Protective Service Worker			
Physiotherapist			
Occupational therapist			
Case Manager			

I _____ authorize the initialed agencies/parties

to:

- discuss information pertaining to me and/or
- release information contained in my record

with or to Participation Lodge Grey-Bruce for the purposes of planning and continuity in the management of my care.

Signature of client or substitute decision maker

Date:_____

Witness

Date:_____

This release may be revoked by the signer at any time.