CONTINUING CARE FACILITY OR COMMUNITY DAY PROGRAM REFERRAL

(FORMERLY CCTRF)

Form compiled by: _____

Date completed: YYYY/MM/DD _____

Continuing Care fax: 867-456-6744

For: ☐ Permanent placement ☐ Respite
☐ Community day program (CDP) ☐ Reablement
☐ Hospice ☐ Hospice respite

Surname	Given name		Date of birth YYYY/MM/DD
Address		City	Postal code
Email	Phone	First Nation no.	Veteran
Physician	Clinic		
YHCIP no.	Pharmacy		
Flu shot ☐ Yes. Date: YYYY/MM/DD ☐ No	COVID-19 vaccine ☐ Yes. 1st dose: YYYY/MM/DD 2nd dose: YYYY/MM/DD ☐ No		TB clearance date (mandatory) YYYY/MM/DD
Home care coordinator		Phone	
Services receiving		Frequency	
Other agencies/programs/treatments involved			
Medical history/diagnosis		Code status ☐ Full code ☐ No code (do not resuscitate) ☐ Unknown ☐ Undecided	
		Advanced directive ☐ Yes ☐ No	
		Psychiatric history ☐ Yes ☐ No	
		Drug allergies	

The personal information contained in this form is collected, used and disclosed in accordance with the *Health Information Privacy and Management Act* and other applicable legislation. Health and Social Services' information practices may be viewed at www.hss.gov.yk.ca/healthprivacy.php.

Diet type
☐ Gluten free ☐ No added sugar ☐ Tube feed ☐ Low lactose

Food texture
☐ Regular ☐ Mechanical soft ☐ Cut up ☐ Minced ☐ Puree

Fluid consistency
☐ Regular ☐ Nectar thick ☐ Honey thick

Special needs or concerns

Food allergies

Food intolerances

Psychosocial status
☐ No concerns ☐ Agitation ☐ Aggression ☐ Anxiety ☐ Suspiciousness
☐ Other: _____

Height	Weight

Communication impairments
☐ Cognitive-communication disorder ☐ Dysarthria
☐ Voice disorder ☐ Aphasia

Dentures
☐ None ☐ Full ☐ Partial

Vision	Uses glasses	Ability to communicate wants/needs/symptoms
☐ Good ☐ Fair ☐ Poor ☐ Legally blind	☐ Yes ☐ No	

Hearing	Hearing aids	Language(s) spoken
☐ Good ☐ Fair ☐ Poor ☐ Deaf	☐ Left ☐ Right	

Mobility devices
☐ Wheelchair ☐ Walker ☐ Prosthesis ☐ Cane

Smoker
☐ Yes ☐ No

Additional equipment used at home (e.g. ostomy, home oxygen, communication devices)

Contact person		Relationship
Address		Email
Home phone	Work phone	Cell phone

Alternate contact		Relationship
Home phone	Work phone	Cell phone

Name

Mobility	**Transferring**
☐ Independent	☐ Independent
☐ Minimal assistance (stand by)	☐ Minimal assistance (stand by)
☐ Moderate assistance (1 person assistance)	☐ Moderate assistance (1 person assistance)
☐ Full assistance (2 person assistance)	☐ Full assistance (2 person assistance / mechanical lift)
Eating	**Toileting**
☐ Independent	☐ Independent
☐ Minimal assistance (tray set up)	☐ Minimal assistance (washroom cueing)
☐ Moderate assistance (feeds self – 50%)	☐ Moderate assistance (assist in washroom – 1 person)
☐ Full assistance or tube feed	☐ Full assistance (2 person assistance)
Special needs	**Elimination**
☐ R.N. treatment	☐ Continent
☐ Footcare	☐ Incontinent – urinary (self managed)
☐ Occupational therapy	☐ Incontinent – urinary (requires assistance)
☐ Physical therapy	☐ Incontinent – bowel (requires assistance)
Social Interaction	**Cognitive status**
☐ Able to interact with individuals and/or in group settings	☐ No concerns
☐ Minimal encouragement needed to participate	☐ Minimal confusion (some STM loss/needs minimal cueing)
☐ Moderate encouragement to interact	☐ Moderate confusion – difficulty following simple directions (needs moderate cueing)
☐ Needs 1-to-1 attention	☐ Maximum confusion (cannot follow directions and difficulty verbalizing needs)
Elopement	**Dressing**
☐ No risk	☐ Independent
☐ Occasional (needs redirection 1-2 times per day)	☐ Minimal assistance (stand by)
☐ Actively attempts to leave (redirection difficult)	☐ Moderate assistance (1 person assistance)
	☐ Full assistance (2 person assistance)
Hygiene (a)	**Hygiene (b)**
Sink tasks (hands, hair, teeth)	**Bathing** (tub, shower)
☐ Independent	☐ Independent
☐ Minimum assistance (stand by)	☐ Minimum assistance (stand by)
☐ Moderate assistance (1 person assistance)	☐ Moderate assistance (1 person assistance)
☐ Full assistance (2 person assistance)	☐ Full assistance (2 person assistance)
Additional medical equipment considerations	
☐ IV meds	☐ Mechanical ventilator, CPAP machine, Bipap
☐ Tracheostomy: additional med supplies (list):	Settings: _____
_____	Hours of use:_____
_____	Independent to turn on and off? ☐ Yes ☐ No
_____	☐ Abdominal pleurex catheter
_____	☐ Thoracic pleurex catheter
☐ Receiving chemo:_____	☐ Defibrillator deactivated ☐ Yes ☐ No
☐ PIC line	☐ Oxygen needs: ☐ Concentrator ☐ Canister
☐ Central line	☐ Rate of oxygen needs:_____

Community Day Program applicants – complete this additional section

Attendance day(s) requested

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Method of transportation

☐ Family ☐ Taxi ☐ Handi-Bus ☐ Walk ☐ Own vehicle ☐ Don't know

Reason for referral

☐ Social ☐ Nutrition ☐ Cognitive ☐ Emotional

Referring agency

Bath requested?

☐ Yes ☐ No

Preferred bath day

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

On placement wait list

☐ Yes ☐ No

Pre-admission tour requested

☐ Yes ☐ No

Current activities and interests

Fax to Continuing Care admissions office: 867-456-6744

For CDP coordinator use only

Total score /55	Admission date	Referring agency notified ☐ Yes ☐ No	Client/family notified ☐ Yes ☐ No

Print Clear