



**SUPPORT SERVICES FOR SENIORS
AND ADULTS WITH DISABILITIES**

Intake Form

Date	Urgent? (Y/N)
<p>We need your permission to collect your personal and health information, and we will need to share this information with our staff and our partners. Your information is private, and unless required by law, we will not give out your information to anyone else without your permission. Do you give consent to this?</p>	
<p style="text-align: right;">Consent? Y N</p>	

Client Information

First Name		Last Name		Gender				
Telephone		Alternate Tel		D.O.B.				
Language Preferred		Special Instructions for Calling						
Marital Status		Family Physician (name and tel)						
Client Address				Intersection				
Living Situation (insert an "X")	<input type="checkbox"/>	Lives Alone	<input type="checkbox"/>	Homeless	<input type="checkbox"/>	Smoker	<input type="checkbox"/>	Drug Use
	<input type="checkbox"/>	Lives Without Support	<input type="checkbox"/>	Temporary Address	<input type="checkbox"/>	Pets		
Comment								
Impairments (insert an "X")	<input type="checkbox"/>	Vision	<input type="checkbox"/>	Speech	<input type="checkbox"/>	Cognitive		
	<input type="checkbox"/>	Hearing	<input type="checkbox"/>	Mobility	<input type="checkbox"/>	Other		
Comment								

Alternate Contact

First Name		Last Name		Tel
Relationship		Comment		

Referral Source (insert an "X")

Referral Contact Name:			Tel:		
<input type="checkbox"/>	Self-referral	<input type="checkbox"/>	LHIN	<input type="checkbox"/>	Spouse or family
<input type="checkbox"/>	Internal (this agency)	<input type="checkbox"/>	Family Physician	<input type="checkbox"/>	Friend or neighbour
<input type="checkbox"/>	Another CSS agency	<input type="checkbox"/>	Hospital	<input type="checkbox"/>	Other (explain)

Storefront Humber Services

(Rec = currently receiving, Req = requested)

Rec	Req	Name of Service	Provider / Comment
		Adult day program	
		Day trips	
		Foot care	
		Gentle fitness	
		Group dining	
		Homemaking	
		Home maintenance & repair	
		Personal care or support	
		Respite	
		Shopping assistance	
		Transportation	
		Are you receiving Wheel Trans Services? Yes No	
		Are you currently receiving service from LHIN or other agencies? Yes No	

Please answer the following questions.

	Y	N	Comment
1. Lives alone without support?			
2. Physical or cognitive impairments?			
3. Admitted to hospital (emergency or otherwise) within 3 months?			
4. Fallen within the last 3 months?			
5. Access to a family physician?			
6. Visited family physician in the last 6 months?			
7. Recently had trouble accessing a health service?			
8. Homeless or temporary address?			
9. Possible caregiver issues (abuse, stress)?			

You can email this form to sfh@storefronthumber.ca

Staff Use Only
FARM? Yes No