



INTAKE FORM

Call toll free: 1- 866- 626- 0222

I. Source Information	
Date of Call:	Time of Call:
Intake Agency Name:	Intake Agency Client ID:
Intake Staff Name:	Intake Staff Phone #:

II. Referral Agency and Services	
1st Referral Agency:	Referral Priority: <input type="checkbox"/> Routine <input type="checkbox"/> Urgent
Services Requested: <input type="checkbox"/> Adult Day Program for Frail Seniors <input type="checkbox"/> Adult Day Program for Seniors with Alzheimer's Disease/ Dementia <input type="checkbox"/> Adult Day Program with Overnight Stay for Seniors with Alzheimer's Disease / Dementia <input type="checkbox"/> Case Management <input type="checkbox"/> Crisis Support & Assistance	<input type="checkbox"/> Foot Care <input type="checkbox"/> Friendly Visiting <input type="checkbox"/> Group Dining <input type="checkbox"/> Health Promotion/Education <input type="checkbox"/> Home Help/Homemaking <input type="checkbox"/> Home Maintenance & Repair <input type="checkbox"/> Meals On Wheels <input type="checkbox"/> Nursing <input type="checkbox"/> Palliative Care
<input type="checkbox"/> Personal Care/Support <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Respite <input type="checkbox"/> Security Check <input type="checkbox"/> Shopping Assistance <input type="checkbox"/> Shopping List Pickup <input type="checkbox"/> Shopping Trips <input type="checkbox"/> Social/ Recreational Activities <input type="checkbox"/> Social Work	<input type="checkbox"/> Specialized Geriatric Services <input type="checkbox"/> Support for Individuals or Families Caring for a Senior <input type="checkbox"/> Support Groups for Individuals or Families Caring for a Senior <input type="checkbox"/> Supportive Housing <input type="checkbox"/> Transportation <input type="checkbox"/> Other:
2nd Referral Agency:	Referral Priority: <input type="checkbox"/> Routine <input type="checkbox"/> Urgent
Services Requested: <input type="checkbox"/> Adult Day Program for Frail Seniors <input type="checkbox"/> Adult Day Program for Seniors with Alzheimer's Disease/ Dementia <input type="checkbox"/> Adult Day Program with Overnight Stay for Seniors with Alzheimer's Disease / Dementia <input type="checkbox"/> Case Management <input type="checkbox"/> Crisis Support & Assistance	<input type="checkbox"/> Foot Care <input type="checkbox"/> Friendly Visiting <input type="checkbox"/> Group Dining <input type="checkbox"/> Health Promotion/Education <input type="checkbox"/> Home Help/Homemaking <input type="checkbox"/> Home Maintenance & Repair <input type="checkbox"/> Meals On Wheels <input type="checkbox"/> Nursing <input type="checkbox"/> Palliative Care
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III. Consent
<p>Doorways to Care needs your permission to collect, use and disclose personal and health information for the purposes of planning and providing services. Doorways to Care will need to share the collected information amongst its partners and authorized staff. Your information is private. Unless sharing is permitted by law, Doorways to Care will not give out your information without your consent. Do you understand and give consent to this?</p>
Verbal consent received from Client or Substitute Decision Maker? <input type="checkbox"/> Yes <input type="checkbox"/> No
Consent Provided By:
Relationship to Client:
<p>In addition you also give Doorways to Care permission to share your information with the following community agencies:</p>

IV. Introductory Information

Reason for Call / Main Concern:

How did you find out about DWTC? Relative/Spouse Friend/Neighbour Agency/Professional Flyer Newspaper
 Internet Poster Other:

Are you **currently receiving services** in your home? Yes No If yes, Agency Name:

Do you have an **existing case manager**? Yes No If yes, Case Manager Name:

Current Services:

<input type="checkbox"/> Adult Day Program for Frail Seniors	<input type="checkbox"/> Foot Care	<input type="checkbox"/> Personal Care/Support	<input type="checkbox"/> Specialized Geriatric Services
<input type="checkbox"/> Adult Day Program for Seniors with Alzheimer's Disease/ Dementia	<input type="checkbox"/> Friendly Visiting	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Support for Individuals or Families Caring for a Senior
<input type="checkbox"/> Adult Day Program with Overnight Stay for Seniors with Alzheimer's Disease / Dementia	<input type="checkbox"/> Group Dining	<input type="checkbox"/> Respite	<input type="checkbox"/> Support Groups for Individuals or Families Caring for a Senior
<input type="checkbox"/> Case Management	<input type="checkbox"/> Health Promotion/Education	<input type="checkbox"/> Security Check	<input type="checkbox"/> Supportive Housing
<input type="checkbox"/> Crisis Support & Assistance	<input type="checkbox"/> Home Help/Homemaking	<input type="checkbox"/> Shopping Assistance	<input type="checkbox"/> Transportation
	<input type="checkbox"/> Home Maintenance & Repair	<input type="checkbox"/> Shopping List Pickup	<input type="checkbox"/> Other:
	<input type="checkbox"/> Meals On Wheels	<input type="checkbox"/> Shopping Trips	
	<input type="checkbox"/> Nursing	<input type="checkbox"/> Social/ Recreational Activities	
	<input type="checkbox"/> Palliative Care	<input type="checkbox"/> Social Work	

Are you **currently on a wait list for a long-term care home**? Yes No

Are you **currently on a wait list for services** in your home? Yes No If yes, Agency Name:

Waitlisted Services:

<input type="checkbox"/> Adult Day Program for Frail Seniors	<input type="checkbox"/> Foot Care	<input type="checkbox"/> Personal Care/Support	<input type="checkbox"/> Specialized Geriatric Services
<input type="checkbox"/> Adult Day Program for Seniors with Alzheimer's Disease/ Dementia	<input type="checkbox"/> Friendly Visiting	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Support for Individuals or Families Caring for a Senior
<input type="checkbox"/> Adult Day Program with Overnight Stay for Seniors with Alzheimer's Disease / Dementia	<input type="checkbox"/> Group Dining	<input type="checkbox"/> Respite	<input type="checkbox"/> Support Groups for Individuals or Families Caring for a Senior
<input type="checkbox"/> Case Management	<input type="checkbox"/> Health Promotion/Education	<input type="checkbox"/> Security Check	<input type="checkbox"/> Supportive Housing
<input type="checkbox"/> Crisis Support & Assistance	<input type="checkbox"/> Home Help/Homemaking	<input type="checkbox"/> Shopping Assistance	<input type="checkbox"/> Transportation
	<input type="checkbox"/> Home Maintenance & Repair	<input type="checkbox"/> Shopping List Pickup	<input type="checkbox"/> Other:
	<input type="checkbox"/> Meals On Wheels	<input type="checkbox"/> Shopping Trips	
	<input type="checkbox"/> Nursing	<input type="checkbox"/> Social/ Recreational Activities	
	<input type="checkbox"/> Palliative Care	<input type="checkbox"/> Social Work	

V. Client Information *If Caller is not the Client, complete box below:*

Best time to call client? **Caller Name:**

OK to leave message on machine? Yes No **Caller Relationship:**

Lives alone? Yes No **Caller Phone#:**

Marital Status: Single Married Widow Other: **Are you a caregiver for the client?** Yes No

English spoken? Yes No If yes, is this a paid caregiver role? Yes No

English understood? Yes No Would you be interested in caregiver support? Yes No

Client's preferred language: **Is the client aware of your call?** Yes No

Other languages:

VI. Alternate Contacts		
Name:	Phone#:	Relationship to Client:
Type of Contact: <input type="checkbox"/> Primary Contact to arrange services <input type="checkbox"/> Caregiver <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Translator <input type="checkbox"/> Substitute Decision Maker <input type="checkbox"/> Power of Attorney – Financial <input type="checkbox"/> Power of Attorney – Personal Care		
Name:	Phone#:	Relationship to Client:
Type of Contact: <input type="checkbox"/> Primary Contact to arrange services <input type="checkbox"/> Caregiver <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Translator <input type="checkbox"/> Substitute Decision Maker <input type="checkbox"/> Power of Attorney – Financial <input type="checkbox"/> Power of Attorney – Personal Care		
Family Doctor Name:	Phone#:	Fax#:
		<input type="checkbox"/> Unknown <input type="checkbox"/> Does not have one
Specialist Name:	Phone#:	Fax#:
		<input type="checkbox"/> Unknown <input type="checkbox"/> Does not have one

VII. Brief Functional Assessment	
1. Health status: In the past year have you gone to the emergency department or have you been admitted to hospital 3 times or more? Have you been to the hospital in the last 3 months for medical attention?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Social Support: Do you need to find ways to connect with others? e.g. through group dining, social activities or friendly visiting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Functional independence (ADL): Do you need help with any of the following: <input type="checkbox"/> Bathing <input type="checkbox"/> Mobility If so, indicate <input type="checkbox"/> Mobility aids <input type="checkbox"/> Transfers and specify type: <input type="checkbox"/> Dressing <input type="checkbox"/> Taking Medications <input type="checkbox"/> Eating <input type="checkbox"/> Toileting <input type="checkbox"/> Foot Care	
4. Instrumental independence (IADL): Do you need help with any of the following: <input type="checkbox"/> Meal Preparation <input type="checkbox"/> Laundry <input type="checkbox"/> Managing Money/Finances <input type="checkbox"/> Housekeeping <input type="checkbox"/> Going to doctor's office <input type="checkbox"/> Shopping <input type="checkbox"/> Transportation	
5. Chronic Disease: Do you have any of the following conditions: <input type="checkbox"/> Arthritis <input type="checkbox"/> Heart attack <input type="checkbox"/> Macular degeneration/Blindness <input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> Parkinson's <input type="checkbox"/> Dementia/Alzheimer's <input type="checkbox"/> Kidney disease <input type="checkbox"/> Stroke <input type="checkbox"/> Depression/Mood disorder <input type="checkbox"/> Lung disease/Emphysema/COPD <input type="checkbox"/> On oxygen at home <input type="checkbox"/> Other:	
Are you taking any medications for the above conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many? Do you need help organizing your medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Recent Falls: Have you had a fall in the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Weight loss/Gain: Have you lost or gained weight recently such that your clothes are not fitting? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Visual/Hearing/Speech Impairment: Do you have any impairment that affects communication with providers? <input type="checkbox"/> Visual <input type="checkbox"/> Hearing <input type="checkbox"/> Speech Comments:	

Additional Comments:

VIII. Evaluation Questions

At the end of each call that results in a service request / referral, please ask the following questions.

1. Have we given you enough information about the services you need?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
2. Are you clear about what will happen next in terms of getting the services you need?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
3. Have we done enough today to address your needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know