HOME CARE CASE ACTION FORM

Manitoba Health

1. CLIENT NAME: _____ Birth Date _____ D/M/Y

M.H.S.C.# _____ PHIN #: _____

ADDRESS: _____ Phone: _____

_____ New Opening
_____ Re-opening
_____ Transfer in from V.O.N. or Coordinating Hospital

OPEN FOR:
_____ Home Care Assessment and/or
_____ Personal Care Home Assessment
_____ Other (specify) _____

Age of Opening _____

Transfer Date _____ D/M/Y

Opening Date _____ D/M/Y

Case Assessors: Nurse: _____ Social Worker: _____

Case Coordinator: _____

2. **NON-ADMISSION** TO HOME CARE:

Non-Admission Date _____ D/M/Y

30 _____ Chronic Care Placement
31 _____ Inter-Regional Transfer
32 _____ Home Care Services Not Required
33 _____ Home Not Suitable For Home Care
34 _____ Person Deceased
35 _____ Admitted To a Care Facility Or Hospital
36 _____ Person Or Family Refused Service
37 _____ Other (Specify) _____

3. **ADMISSION** TO THE HOME CARE PROGRAM: ___ Admission ___ Re-Admission Admission Date _____ D/M/Y

4. **SOURCE OF REFERRAL** FOR ADMISSIONS: (Check One) A _____ Self B _____ Doctor C _____ Hospital D _____ Family/Friend E _____ Other Agency F _____ Own Agency

5. **CARE LEVEL EQUIVALENT** AT POINT OF ADMISSION/RE-ADMISSION: (If Home Care were not available, what equivalent level of facility care would be required for the individual? (Check One)

1 _____ Personal Care Home Level I
2 _____ Personal Care Home Level II
3 _____ Personal Care Home Level III
4 _____ Personal Care Home Level IV
5 _____ Post Acute Care
6 _____ Hospital – Extended Care/Long Term
7 _____ Other Facility _____
8 _____ No Facility Care Level Equivalent

6. **DISCHARGE** FROM THE HOME CARE PROGRAM: (Check One) Discharge Date _____ D/M/Y

_____ Person Deceased
_____ Personal Care Home Placement
_____ Other (Specify) _____
_____ Hospital Admission including Extended Care Hospital
_____ Home Care No Longer Required/Service Provided By Other
_____ Home Care No Longer Required/Person Improved/Recovered