

HOME CARE TRANSFER FORM – AGENCY TO AGENCY

Manitoba
Health



TO: _____

FROM: _____

DATE OF TRANSFER: _____

PHIN: _____

CLIENT'S NAME	SURNAME	GIVEN NAMES	SEX	BIRTHDATE	PHONE NUMBER
HOME ADDRESS					POSTAL CODE
BAND NAME		TREATY NUMBER		MHSC NUMBER	
REGION	AREA OFFICE	CAN PERSON COMMUNICATE IN ENGLISH? Yes No		IN WHICH LANGUAGE DOES PERSON COMMUNICATE BEST?	
PRESENT LOCATION		SAME AS ADDRESS OTHER (SPECIFY)			
MARITAL STATUS: MARRIED ___ SINGLE ___ WIDOWED ___ DIVORCED/SEPARATED ___ OTHER ___					
NEXT OF KIN OR PERSON RESPONSIBLE (NAME)			RELATIONSHIP		PHONE NUMBER
ADDRESS					POSTAL CODE
NAME OF KIN OR PERSON RESPONSIBLE (NAME)			RELATIONSHIP		PHONE NUMBER
ADDRESS					POSTAL CODE
PHYSICIAN'S NAME					PHONE NUMBER
ADDRESS					POSTAL CODE
DIAGNOSIS (EXTENT OF DISABILITY)				DIAGNOSIS KNOWN: TO FAMILY TO PERSON ___ YES ___ YES ___ NO ___ NO	
COMMUNICATION (SPECIFY IF PROBLEM)					

MEDICATIONS	PRESENT TREATMENTS
UNDERSTANDS YES ___ NO ___ PARTIAL ___	VITAL SIGNS
COMPLIANCE YES ___ NO ___ PARTIAL ___	

1. Ambulation
- | | | | |
|--------------------------|------------------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | Unlimited with or without much aid | <input type="checkbox"/> | Bed to chair |
| <input type="checkbox"/> | Outdoors with assistance | <input type="checkbox"/> | Bed to chair with assistance |
| <input type="checkbox"/> | Indoors, amb. with assistance | <input type="checkbox"/> | Bedfast – can turn self |
| <input type="checkbox"/> | Wheelchair independent | <input type="checkbox"/> | Bedfast – must be turned |
| <input type="checkbox"/> | Wheelchair with assistance | <input type="checkbox"/> | Cannot manage stairs |
| | | <input type="checkbox"/> | Stairs with assistance |
| | | <input type="checkbox"/> | Stairs independent |

Reason: _____

Current Management: _____

Planned Intervention: _____

2. Elimination
- | | | | |
|--------------------------|--|--------------------------|---------------------------|
| <input type="checkbox"/> | Completely continent | <input type="checkbox"/> | Incontinent feces, always |
| <input type="checkbox"/> | Incontinent urine, night only accident | <input type="checkbox"/> | Completely incontinent |
| <input type="checkbox"/> | Incontinent urine, always | <input type="checkbox"/> | Other (specify) |
| <input type="checkbox"/> | Incontinent feces, occ. | | |
| <input type="checkbox"/> | Retention of urine | | |

Reason: _____

Current Management: _____

Planned Intervention: _____

3. Mental Status
- | | | | |
|--------------------------|---------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | Completely oriented | <input type="checkbox"/> | Depressed |
| <input type="checkbox"/> | Forgetful, occ. | <input type="checkbox"/> | Anxious |
| <input type="checkbox"/> | Confused, etc. | <input type="checkbox"/> | Bizarre behaviour (specify) |

Reason: _____

Current Management: _____

Planned Intervention: _____

4. Personal Care

- Bathing
- | | | | |
|--------------------------|----------------------------------|--------------------------|--|
| <input type="checkbox"/> | Independent with shower or bath | <input type="checkbox"/> | Can bath only with supervision, assistance |
| <input type="checkbox"/> | Independent with mechanical aids | <input type="checkbox"/> | Has to be bathed |
| <input type="checkbox"/> | Can sponge bath self | | |

Reason: _____

Current Management: _____

Planned Intervention: _____

- Dressing
- | | | | |
|--------------------------|------------------------------|--------------------------|---|
| <input type="checkbox"/> | Independent | <input type="checkbox"/> | Can dress/undress with minimal assistance |
| <input type="checkbox"/> | Independent with supervision | <input type="checkbox"/> | Requires considerable assistance |
| | | <input type="checkbox"/> | Has to be dressed/undressed |

Reason: _____

Current Management: _____

Planned Intervention: _____

