



DIRECT CARE NO.		RESP. H.U. NO.		OFFICE I.D. NO.		HNC / CPO AREA		ACTIVE DIRECT CARE <input type="checkbox"/> LTC <input type="checkbox"/> HNC <input type="checkbox"/> CPO			INACTIVE DIRECT CARE <input type="checkbox"/> LTC <input type="checkbox"/> HNC <input type="checkbox"/> CPO		
NAME (FAMILY SURNAME)				GIVEN NAME				INITIAL		PHONE NO.			
ADDRESS								CITY			POSTAL CODE		
GENDER <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE YYYY MM DD		AGE	MARITAL STATUS 1 <input type="checkbox"/> S 2 <input type="checkbox"/> M 3 <input type="checkbox"/> W 4 <input type="checkbox"/> D 5 <input type="checkbox"/> SEP 6 <input type="checkbox"/> AL SPOUSE 98 <input type="checkbox"/> UNKNOWN				PERSONAL HEALTH NUMBER					
CLIENT GROUP <input type="checkbox"/> 1A-ACUTE <input type="checkbox"/> 1B-END OF LIFE <input type="checkbox"/> 1C-LONG TERM SUPPORTIVE <input type="checkbox"/> 1D-MAINTENANCE <input type="checkbox"/> 1E-REHAB			ABORIGINAL ORIGIN <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 98		ACQUIRED BRAIN INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO		DEVELOPMENTAL DISABILITY <input type="checkbox"/> YES <input type="checkbox"/> NO		HA CLIENT #				
NAME OF CONTACT PERSON 1				NAME OF CONTACT PERSON 2				PHONE NO. (S)					
ADDRESS OF CONTACT PERSON 1				ADDRESS OF CONTACT PERSON 2				REFERRAL SOURCE					
								REFERRAL DATE YYYY MM DD					
ADMIT EFFECTIVE DATE YYYY MM DD		PHYSICIAN NO.		REFERRING PHYSICIAN				PHONE NO.					
RESPONSIBLE PHYSICIAN								PHONE NO.					
OTHER PHYSICIANS INVOLVED IN CARE								PHONE NO.					
HOSPITAL NO.		HOSPITAL NAME					WARD		ADMIT NO.				
CARE GROUP TYPE		EXTENDED BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		OTHER FUNDING? <input type="checkbox"/> YES <input type="checkbox"/> NO		ORG.		SERVICE TYPE		LIVES ALONE?			
PRIMARY DIAGNOSIS								ALLERGIES					
SECONDARY DIAGNOSIS													
OPERATION						DATE YYYY MM DD							

VISITS (HNC/CPO/PHN)	MONTH						VISITS (SUB TOTAL)

DISCHARGE EFFECTIVE DATE YYYY MM DD		EST. PROGRAM STAY		PROJECTED GOALS		PATIENT OUTCOME		DISPOSITION		TOTAL VISITS	
LOCAL INFORMATION											

Personal information on this form is collected for operations of Direct Care Services within the community. The information will be used to determine the applicant's functional and self care capabilities and for provincial health care planning purposes. Personal information will be used and disclosed in accordance with the privacy protection provisions of the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection, use and disclosure of the information, you should contact your home care nurse, physiotherapist, or occupational therapist at your local health unit, which is listed in the blue pages of the telephone book under Health Authorities.