HOME CARE
TRANSFER FORM – AGENCY TO AGENCY

Manitoba Health

TO: _____

FROM: _____

DATE OF TRANSFER: _____

PHIN: _____

CLIENT'S NAME SURNAME GIVEN NAMES	SEX	BIRTHDATE D M Y	PHONE NUMBER
HOME ADDRESS			POSTAL CODE

BAND NAME	TREATY NUMBER	MHSC NUMBER
REGION AREA OFFICE CAN PERSON COMMUNICATE IN ENGLISH?		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 ___ YES ___ NO TO PERSON ___ YES ___ NO
COMMUNICATION (SPECIFY IF PROBLEM)		

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

1. Ambulation

_____ Unlimited with or without much aid
_____ Outdoors with assistance
_____ Indoors, amb. with assistance
_____ Wheelchair independent
_____ Wheelchair with assistance
_____ Bed to chair
_____ Bed to chair with assistance
_____ Bedfast – can turn self
_____ Bedfast – must be turned
_____ Cannot manage stairs
_____ Stairs with assistance
_____ Stairs independent

Reason: _____
Current Management: _____
Planned Intervention: _____

2. Elimination

_____ Completely continent
_____ Incontinent urine, night only accident
_____ Incontinent urine, always
_____ Incontinent feces, occ.
_____ Retention of urine
_____ Incontinent feces, always
_____ Completely incontinent
_____ Other (specify)

Reason: _____
Current Management: _____
Planned Intervention: _____

3. Mental Status

_____ Completely oriented
_____ Forgetful, occ.
_____ Confused, etc.
_____ Depressed
_____ Anxious
_____ Bizarre behaviour (specify)

Reason: _____
Current Management: _____
Planned Intervention: _____

4. Personal Care

Bathing

_____ Independent with shower or bath
_____ Independent with mechanical aids
_____ Can sponge bath self
_____ Can bath only with supervision, assistance
_____ Has to be bathed

Reason: _____
Current Management: _____
Planned Intervention: _____

Dressing

_____ Independent
_____ Independent with supervision
_____ Can dress/undress with minimal assistance
_____ Requires considerable assistance
_____ Has to be dressed/undressed

Reason: _____
Current Management: _____
Planned Intervention: _____

4. Personal Care (continued)

Eating

_____ Independent
_____ Independent with mechanical aids if food cup up
_____ Requires assistance or encouragement
_____ Has to be fed

Reason: _____

Current Management: _____

Planned Intervention: _____

Daily Functioning (Specify if any problem in shopping, preparation of meals, household cleaning, use of phone and/or household chores)

_____

_____

Reason: _____

Current Management: _____

Planned Intervention: _____

5. Social Functioning

Judgement in present environment

_____ Realistic
_____ Adequate for personal safety
_____ Limited ability to make judgement
_____ Unrealistic

Reason: _____

Current Management: _____

Planned Intervention: _____

Living Arrangements

_____ Satisfactory
_____ Unsatisfactory
_____ Alone
_____ Bedridden
_____ Foster Home
_____ With Relative
_____ Other (specify) _____

Reason: _____

Current Management: _____

Planned Intervention: _____

Participation in Activities (Observations of worker. Please comment on each section).

a) How does the individual spend his/her time? _____

_____

b) What other activities and contacts would the individual like to have? _____

_____

c) Identify cultural and religious preferences relevant to the delivery of Home Care Services _____

_____

Participation in Activities (as viewed by client) _____ Satisfactory _____ Unsatisfactory

Reason: _____

Current Management: _____

Planned Intervention: _____

Social Functioning (continued)

Degree of Supportiveness of Family (as viewed by client)

_____ Supportive _____ Non Supportive

_____ Sometime Supportive _____ Specify Nature of Support _____

Reason: _____

Current Management: _____

Planned Intervention: _____

Degree of Supportiveness of Friends/Neighbours (as viewed by client)

_____ Supportive _____ Non Supportive

_____ Sometime Supportive _____ Specify Nature of Support _____

Reason: _____

Current Management: _____

Planned Intervention: _____

REASON FOR TRANSFER _____

CARE PLAN AND GOALS (Summary) _____

PRESENT SERVICES: INDICATE FREQUENCY AND TYPE OF SERVICE BEING PROVIDED (If Applicable)

SERVICE	TYPE	SOURCE/AGENCY	FREQUENCY	ACTIVITY	AUTHORIZED
Nursing					
Therapy					
H.M.					
Meal Delivery					
Adult Day Program					
Day Hospital					
Equipment					
Supplies (Drsg. Etc.)					
Other					