Participation Lodge & Community Services

APPLICATION FOR SERVICE

Program Applied For:

☐ **Acquired Brain Injury Program** ☐ **Residential Program** ☐ **Hanover Apartment** ☐ **Owen Sound Apartment**

☐ **Outreach**

Name of Applicant			Gender	Birth date
Surname	First name	Preferred	M F	Day / Month / Year

CURRENT ADDRESS

Agency / Organization (if applicable)			
Address:	House #: Street:		
	City:	Province: Postal Code:	Home Phone #:
			County

PRIMARY CONTACT

Contact Name			**Relationship to Client:**
Address:	House #: Street:		
	City:	Province: Postal Code:	Home Phone #:
			Work Phone #:

Section A. DEMOGRAPHIC INFORMATION

Residential History: (list the places client has lived starting with most recent)

Place	Dates (from-to)	Reason for Leaving

EDUCATIONAL HISTORY:
Highest Grade Completed

Marital Status: ☐ Never married ☐ Divorced/ Separated ☐ Married

SOURCE OF INCOME:

☐ ODSP ☐ CPP ☐ Self / family ☐ Insurance/ third party funding
☐ WSIB ☐ Unemployment insurance Other:

OCCUPATION:

Section B. MEDICAL INFORMATION AND HISTORY

Health Card Number	**Drug Card Number**

Physician:		Phone #:
Physician's Hospital		Phone # of Hospital:
Pharmacy Used:		Phone # of Pharmacy

ALLERGIES **List all food, drugs, latex, environmental allergies**

Allergy	Reaction	Intervention required

Continue on back of sheet if more space required

DIAGNOSIS	**Year of Diagnosis**
Primary Diagnosis:	
Secondary Diagnosis (s):	

Weight: lbs.	**Height:**	

Does Client smoke? ☐ Yes ☐ No	Does Client use "street" drugs? ☐Yes ☐No	Is client permitted alcohol?

PHYSICAL HEALTH: Do you experience any of the following (Please indicate on back of page how these are managed.)

Endocrine/metabolic/ Nutritional
- ☐ Diabetes
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Bulima
- ☐ Anorexia
- ☐ constipation
- ☐ Stomach problems
- ☐ Menstrual disorder
- ☐ Liver Disease
- ☐ Chronic diarrhea
- ☐ Kidney disease

Heart/ Circulation
- ☐ Heart disease
- ☐ Congestive heart failure
- ☐ Deep vein thrombosis
- ☐ Hypertension
- ☐ Hypotension
- ☐ Peripheral edema

Musculoskelatal
- ☐ Arthritis
- ☐ Missing limb/ amputation
- ☐ Osteoporosis
- ☐ Pathological bone fracture
- ☐ Spinal Muscular Atrophy
- ☐ Spinal Cord injury
- ☐ ALS
- ☐ joint inflammation

Psychiatric/Mood
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar
- ☐ Schizophrenia
- ☐ delusions
- ☐ obsessive compulsive

Sensory
- ☐ Cataracts
- ☐ Diabetic retinopathy
- ☐ Gluacoma
- ☐ Macular degeneration

Neurological
- ☐ Alzheimer's
- ☐ Cerebral palsy
- ☐ Stroke
- ☐ Aphasia
- ☐ Hemiplegia/ hemiparesis
- ☐ Parapalegia
- ☐ Quadriplegia
- ☐ Seizure disorder
- ☐ Traumatic brain injury
- ☐ Vertigo
- ☐ pica
- ☐ multiple sclerosis
- ☐ muscular dystrophy
- ☐ Headaches
- ☐ Tourettes
- ☐ ADD/ ADHD
- ☐ Autism
- ☐ Hydrocephalus
- ☐ Downs Syndrome
- ☐ Developmental delay

Other
- ☐ Anemia
- ☐ Cancer
- ☐ Renal failure
- ☐ Weight loss/gain
- ☐ Insomnia
- ☐ Night mares
- ☐ Drug abuse
- ☐ Alcohol abuse
- ☐ Shingles:
- ☐ Rashes/ skin disorders
- ☐ Bleeding disorder

Infections
- ☐ Antibiotc Resistant
- ☐ Infection (MRSA)
- ☐ Clostridum difficile
- ☐ Conjuntivitis
- ☐ Aids/ HIV
- ☐ Pneumonia
- ☐ Septicemia
- ☐ Tuberculosis
- ☐ Urinary tract inf
- ☐ Hepatitis
- ☐ Immune Disorders

Pulmonary
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Shortness of breath Apnea
- ☐ Tracheotomy
- ☐ oxygen use
- ☐ Ventilator

IMMUNIZATIONS

If status is unknown you may be required to be re-immunized.	CURRENT?				CURRENT?			Have you had any of these illnesses?
	Yes	No	Not sure		Yes	No	Not Sure	
Pertussis				Rubella (German measles)				
Diphtheria				TB skin test				
Tetanus				Chicken pox				
Polio				Hepatitis A				
Measles				Hepatitis B				
Mumps				Flu Shot				
Pneumovax				**ATTACH COPY OF IMMUNIZATION RECORD**				

ACQUIRED BRAIN INJURY CLIENTS

Date of Injury:	Cause of Brain injury: (mva, anoxia, etc)
Ranchos Los Amigos Score: (circle appropriate level) *1 2 3 4 5 6 7 8*	**Was client in coma?** ☐ Yes ☐ No Length of coma:_____

Hospitalization Information:	Name of facility	How long?
Acute Care hospital		
Rehabilitation		
Long term care		

Are you currently receiving rehabilitation services? ☐ Yes ☐ No	Explain
Are you currently receiving other support services? ☐ Yes ☐ No	

***COMPLETE THE ABI CHECKLIST ATTACHED**

SEIZURES:

Is Client subject to seizures? **Yes** ☐ **No** ☐

Describe a typical seizure	How often does Client have seizures?	How long does seizure usually last?

Movement

Interventions required during / after seizure:

Expected behavior before and after

	MEDICINE NAMES	Dosage	Times Taken	Reason Why Client Takes This Medicine
PRESCRIBED BY PHYSICIAN				
Non- prescription				
TREATMENTS	**What**	**When**	**Where**	**Why**

Does have any problems with medications?	How does Client take medications?

Section C Activities of Daily Living

DIET & EATING HABITS

Diet:	☐ Regular ☐ Vegetarian ☐ Soft ☐ Pureed ☐ Cut into bite size pieces ☐ Straw ☐ Special utensils other:
Type of diet	
Disorders	☐ Diabetes ☐ Anorexia ☐ Bulimia ☐ Prader Willi ☐ Other
Eating habits	☐ Hearty ☐ Average ☐ Fussy/Poor
Difficulties	☐ Swallowing ☐ Chewing ☐ Drinking ☐ No difficulties
Yes ☐ No ☐	Does client frequently get pale or sweaty, gag or choke during feeding?
Yes ☐ No ☐	Dietary restrictions? explain

Does Client have a G-tube ☐ J-tube ☐	○ gravity ○ push ○ pump					
Times						
Formula						
Amount						
Water						
Run in over …. min						

Yes ☐ No ☐	Does Client take anything by mouth? Explain
Further eating instructions:	

SLEEP

Yes ☐ No ☐	Bed rails required?
Yes ☐ No ☐	Does Client require turning at night? Number of times:_____
Yes ☐ No ☐	Sleep difficulties? Explain:
Bed time:	Wake up:

Speech: ☐ clear/distinct ☐ unclear ☐ no speech

Making Self understood:
- ☐ Understood easily
- ☐ Has some difficulty but can make self understood
- ☐ Ability is limited to making concrete requests
- ☐ Rarely/never understood

Communication Methods: ☐ Words ☐ Technical aid ☐ Communication board ☐ sign language

ORAL / DENTAL STATUS

- ☐ Has dentures or removable bridge
- ☐ Some / all natural teeth lost (no dentures)
- ☐ Broken, loose or carious teeth
- ☐ Inflamed gums, swollen bleeding gums,
- ☐ Pockets /Holds food in mouth
- ☐ Swallowing problems
- ☐ Chewing problems

Vision

- ☐ Adequate (see fine detail, including regular print)
- ☐ Slight impairment
- ☐ Moderate impairment
- ☐ Side vision problems(difficulty traveling, bumps into people / objects etc)
- ☐ No vision or see only light,colors or shapes

☐ Glasses ☐ white cane

Hearing

- ☐ Hears adequately
- ☐ Minimal difficulty
- ☐ Difficulty in hearing in noisy environments
- ☐ Highly impaired / absence of useful hearing

☐ Hearing aid ☐ lip reading ☐ sign language

BLADDER AND BOWEL ROUTINE

Does Client have bladder control:

During the day? ☐ Yes ☐ No
During the night? ☐ Yes ☐ No

Does Client have bowel control:

During the day? ☐ Yes ☐ No
During the night? ☐ Yes ☐ No

Does client have difficulty having a bowel movement?
☐ Yes ☐ No

How often does client have a bowel movement?

What does client use for:

Urination	**Bowel movement**
☐ Toilet	☐ Toilet
☐ Commode	☐ Commode
☐ Diapers/ Attends	☐ Diapers/ Attends
☐ Indwelling catheters	☐ Colostomy
☐ Ileoconduit	☐ Disempactions
☐ Intermittent catheterizations	☐ Stimulation
☐ Catheter irrigations	☐ Fleet enema
☐ Condom drainage	☐ Suppositories
☐ Urinal	☐ Tap water enema
	☐ Stool softeners
	☐ laxatives

incontinent products, when are they worn?

☐ Day use only ☐ Night use only
☐ For bowel routines only ☐ At all times
☐ Other (explain)

Is Client on toileting schedule? ☐ Yes ☐ No
Explain schedule:

AMBULATION and TRANSFER

Method: ☐ weight bears ☐ Walks ☐ canes/crutches ☐ Walker ☐ scooter ☐ electric w/c ☐ Manual w/c-requires pushing ○ yes ○ no

TRANSFERS	Self	Min assist 1 person assist	1 person pivot	2 person standing pivot	2 person assist	Mechanical lift	Constant supervision	Transfer pole	Slide board
In and out of wheelchair									
In and out of shower/tub									
On / off toilet									
Bed transfers									
walking									

Distance able to walk:

Date w/c or mobility aid purchased:

Vendor Mobility aid purchased from:

PHONE#

MENSTRUAL CYCLE

Not Applicable ☐ regular ☐ irregular ☐

Could Client be pregnant?
☐ Yes ☐ No

Comments:

SUPPORT NETWORK

List persons that the client is close to

Name of person	Relationship	Freq of contact	Phone #

BEHAVIOR AND SOCIAL SKILLS

All **AQUIRED BRAIN INJURY** CLIENTS Are required to complete **SECTION B** *THE ABI CHECK LIST.*	**All other clients complete section A below.**

If further information is required other clients may also be asked to complete ABI checklist as well.

	A. BEHAVIOR Check of f all behaviors exhibited	Frequency Exhibited		**A. BEHAVIOR Check off all behaviors exhibited**	Frequency Exhibited
	No unusual behavior			Repetitive sounds, disruptive sounds,	
	Obsessive compulsive behaviors			screaming,	
	Stealing, rummaging			sexual behavior,	
	Wanders, runs away			disrobing in public	
	Withdrawn/ shy			Smearing food/ feces	
	Depressed, crying, tearfulness			self-abusive acts	
	Exaggeration of physical or other problems to seek attention			Temper tantrums	
	Attention seeking behaviors / Demanding			Verbally aggressive	
	Resistive to care(ADL's, meds, food)			Persistent anger with self or others	
	Repetitive questioning			Physically aggressive towards others	
	Expressions of what appear to be unrealistic fears			Fixates on others, obsessively	
	OTHER: (list)				

BEHAVIORS / SOCIAL SKILLS (to be completed by all clients)

Describe in detail - Severity, cause and early warning signs of behaviors indicated in Sections A or B.

What is the typical intervention in these instances?

Have there been any behavioral changes in the last year? ☐ No ☐ Yes (explain)

Is the client on Medications that controls or alters behavior? ☐ Yes ☐ No	**Is a Behavior Management Program used?** ☐ No ☐ Yes (Please outline in detail on separate page)

BEHAVIORS AND SOCIAL SKILLS

Does the Client most enjoy spending time :

- ☐ Alone
- ☐ In Groups
- ☐ Both

Choose one of the options below to best describe social interaction

- ☐ No difficulties functioning in group/ social situations
- ☐ Does not do well in group/ social situations
- ☐ Requires complete supervision within social situations
- ☐ May need prompting and encouragement when getting involved in new experiences

Choose one of the options below to describe decision making skills:

- ☐ Independent (no assistance necessary)
- ☐ Some difficulty in new situations
- ☐ Decisions poor, cues/ supervision required
- ☐ Needs total assistance (never/rarely makes decisions

Sexuality: Please comment on any concerns regarding sexual issues

Does client have any significant fears?

SAFETY

Yes	No		Yes	No	
☐	☐	Is client able to be left unattended for extended periods of time How frequently does client need to be checked on: a) during waking hours: every_____ b) during sleeping hours: every_____	☐	☐	Can client be left alone when smoking
			☐	☐	Is client at risk for falls
			☐	☐	Bed rails
			☐	☐	Restraint used
			☐	☐	Suicidal behavior/ self injurious behavior
☐	☐	Does client require constant 24 hour supervision	☐	☐	At risk for exploitation ,easily manipulated and inappropriately persuaded by others In areas of financial, and sexual matters
☐	☐	Is client an elopement risk, wanders etc			

ACTIVITY PURSUITS

Cycle of Daily events

- ☐ Stays up late at night
- ☐ Naps regularly during day
- ☐ Goes out 1+ days a week
- ☐ Stays busy with hobbies, reading or fixed daily routine
- ☐ Spends most of time alone or watching TV
- ☐ In bed clothes most of day

Involvement Patterns

- ☐ Daily contact with relatives/close friends
- ☐ Usually attends church, temple, etc
- ☐ Involved in group activities
- ☐ Prefers to spend time alone
- ☐ Actively participates
- ☐ Participates with encouragement

Interests

- ☐ Cards/ other games
- ☐ Crafts / arts
- ☐ Exercise/ sports
- ☐ Music
- ☐ Reading/ writing
- ☐ Spiritual/ religious activities
- ☐ Trips/shopping
- ☐ Outdoors
- ☐ TV/ movies
- ☐ Swimming

LIST ALL OTHER ACTIVITIES WHICH CLIENT LIKES TO PARTICIPATES IN

D. SPECIAL TREATMENTS AND PROCEDURES

SKIN CARE

List All skin conditions (rashes, boils, acne, bruising ,lesions, etc)

ULCERS/ WOUNDS

Is client prone to skin ulcers/ wounds? ☐ Yes ☐ No

☐ Pressure Ulcers ☐ Stasis Ulcers ☐ _____

Frequency of Occurrence:_____

SKIN TREATMENTS

- ☐ Pressure relieving device for chair
- ☐ Pressure relieving device for bed
- ☐ Turning/ positioning program
- ☐ Nutrition or hydration interventions to manage skin problems
- ☐ Sterile dressings
- ☐ Application of ointments/ medications

FOOT CARE

Client has one or more of the following:

- ☐ Corns, calluses, bunions, hammer toes, overlapping toes, structural problems
- ☐ Infection of the foot (athletes foot, Cellulitus,etc)
- ☐ Open lesions on foot
- ☐ Requires advance foot care (chiropodist, podiatrist etc)
- ☐ Special shoes, inserts, pads, toe separators

SPECIALIZED TREATMENTS AND PROGRAMS

- ☐ Chemotherapy
- ☐ Dialysis
- ☐ Ostomy care
- ☐ Suctioning
- ☐ Tracheostomy
- ☐ Oxygen therapy
- ☐ Nebulizer treatments
- ☐ Ventilator / respirator
- ☐ Apnea monitor
- ☐ Speech/ language therapy
- ☐ Occupational therapy
- ☐ Physical therapy (ROM etc)
- ☐ Respiratory therapy
- ☐ Psychological therapy
- ☐
- ☐

PAIN

Pain Site	Frequency	Intensity
☐ Back pain ☐ Bone pain ☐ Joint pain ☐ Chest pain ☐ Hip pain ☐ Headaches ☐ Stomach pain ☐ Muscle pain ☐ Other:	☐ No pain ☐ Pain less than daily ☐ Pain daily	☐ Mild pain ☐ Moderate pain ☐ Times when pain is horrible or excruciating

SPLINTS AND PROSTHESIS

Type of splint / prosthesis	Where worn	When worn

STABILITY OF CONDITIONS

- ☐ Stable
- ☐ Conditions/ diseases make client's cognitive , ADL, mood or behavior patterns unstable (fluctuating, or deteriorating)
- ☐ Client experiencing end stage disease (explain)

PUBLICITY:

May we use photo's or video's of you to promote Participation Lodge & Community Services? ☐ Yes ☐ No

ASSISTANCE NEEDED							
PLEASE INDICATE THE LEVEL OF CARE REQUIRED FOR EACH ACTIVITY							
ACTIVITY	**I** Independence	**R** reminders only	**V** verbal prompting	**H** hand over hand assistance	**F** full assistance	Time required in min to complete task	Explain support required
ROM, physio programs							
Dressing lower body/upper body							
Eating							
Bowel movements							
Urinating							
Brushing teeth							
Washing hands/face							
Shaving							
Showering/bathing							
Menstrual hygiene							
Administration of medications							
Ordering medications							
Housekeeping							
Laundry							
Menu planning							
Meal preparation							
Grocery shopping							
Finances							
Medical appointments							

Does client have a Power of Attorney for Personal Care? ☐ Yes ☐ No	**Does Client have Power of Attorney for Finance?** ☐ **Yes** ☐ **No**
Name:	Name:
Phone #:	Phone #:
Address:	Address:

Does Client utilize Public Guardian and Trustee? ☐ Yes ☐ No	Name:
	Phone #:

I confirm that all information provided is accurate and complete to the best of my knowledge.

Name of Person completing Application	First (PRINT) Last	Relationship to Applicant

Signature of Person completing application	Date
Signature of Applicant	Date
Signature of Substitute Decision Maker	Date

To be completed by Admission Committee From Participation Lodge & Community Services

Date Application Rec'd	Program Applied For: ☐ ABI ☐ Outreach ☐ Hanover Apt ☐ Owen Sound Apt	**Placement offered:**
Date Reviewed by Admissions & Discharge Committee	☐ Residential # of hours of service required_____ per ○ day ○ week	Program Offered: ○ ABI ○ Outreach ○ Hanover Apt ○ Owen Sound Apt ○ Residential
	Meets Eligibility for applied for program? ○ Yes ○ No	
	○ Letter of regret sent Date:	Date offered: ○ Accepted ○ Declined
Person reviewing application	○ Placed on Waiting list Date	○ Release of information obtained
	○ Letter sent confirming acceptance to waiting list Date:	○ Service Agreement completed and signed ○ Service Plan completed

PLEASE LIST NAMES AND PHONE NUMBERS OF THE VARIOUS PROFESSIONAL SERVICES			
	Name	Address	Phone Number
FAMILY PHYSICIAN General Practioner			
PHYSICIAN: Specialist			
Psychologist			
Psychiatrist			
Behavior Management			
Pharmacy:			
Dentist:			
Optometrist			
Social Worker			
Adult Protective Service Worker			
Physiotherapist			
Occupational therapist			
Case Manager			

I _____ authorize the initialed agencies/parties

_____

to:

- discuss information pertaining to me and/or
- release information contained in my record

with or to Participation Lodge Grey-Bruce for the purposes of planning and continuity in the management of my care.

_____

Signature of client or substitute decision maker Date:_____

_____ Date:_____

Witness

This release may be revoked by the signer at any time.