



MICBA FORUM ITALIA COMMUNITY SERVICES

155 Forum Drive, Suite 111  
Mississauga ON L4Z 3M9

T: 905.507.2711

F: 905.507.3016

E: communityinfo@forumitalia.com

www.MICBA.com

## INTAKE AND REFERRAL FORM

M.I.C.B.A. Forum Italia Community Services

I. Client Information								
<b>Client Name:</b>			<b>Date of Birth</b> (yyyy/mm/dd):			<b>Gender:</b>		
<b>Client Address:</b>			<b>Apt.:</b>	<b>City:</b>	<b>Postal Code:</b>			
<b>Phone Number:</b>				<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Other:				
<b>English spoken?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>English understood?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>Client's preferred language:</b>			
<i>If you are not the Client, complete box below:</i>								
<b>Name:</b>				<b>Phone#:</b>				
<b>Relationship:</b>		<b>Is the client aware of your referral ?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>Are you a caregiver for the client?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
II. Alternate Contact								
<b>Name:</b>			<b>Phone#:</b>		<b>Relationship to Client:</b>			
<b>Type of Contact:</b> <input type="checkbox"/> Caregiver		<input type="checkbox"/> Power of Attorney – Personal Care / SDM			<input type="checkbox"/> Translator			
<input type="checkbox"/> Primary Contact to arrange services		<input type="checkbox"/> Emergency Contact			<input type="checkbox"/> Other:			
III. Referral Source								
<input type="checkbox"/> Self-referral		<input type="checkbox"/> Internal (your organization)		<input type="checkbox"/> Family Physician		<input type="checkbox"/> Other (i.e. religious affiliate, physiotherapist, etc):		
<input type="checkbox"/> Spouse or family		<input type="checkbox"/> Ontario Health		<input type="checkbox"/> Hospital				
<input type="checkbox"/> Friend or neighbour		<input type="checkbox"/> CSS Agency		<input type="checkbox"/> Specialized Geriatric Services (SGS)				
IV. Current Services C = currently on service, W = waitlisted								
<b>Please Note:</b> If you are NOT receiving any services, but feel services are required please go to page 2 of this form.								
C	W	Service	Provider / Comment		C	W	Service	Provider / Comment
<input type="checkbox"/>	<input type="checkbox"/>	Acquired Brain Injury Services			<input type="checkbox"/>	<input type="checkbox"/>	Meals Delivery	
<input type="checkbox"/>	<input type="checkbox"/>	Adult Day Program			<input type="checkbox"/>	<input type="checkbox"/>	Nursing	
<input type="checkbox"/>	<input type="checkbox"/>	Bereavement Support			<input type="checkbox"/>	<input type="checkbox"/>	Overnight Stay -Group	
<input type="checkbox"/>	<input type="checkbox"/>	Caregiver Support			<input type="checkbox"/>	<input type="checkbox"/>	Personal Care/Support	
<input type="checkbox"/>	<input type="checkbox"/>	Case Management			<input type="checkbox"/>	<input type="checkbox"/>	Rehabilitation	
<input type="checkbox"/>	<input type="checkbox"/>	Crisis Intervention, Support			<input type="checkbox"/>	<input type="checkbox"/>	Safety or Security Check	

Affiliated with:

 MISSISSAUGA ITALIAN CANADIAN BENEVOLENT ASSOCIATION

 VILLA FORUM LONG TERM CARE HOME

 FORUM ITALIA NON-PROFIT HOUSING CORPORATION

 FORUM ITALIA DAYCARE NON-PROFIT INC.

<input type="checkbox"/>	<input type="checkbox"/>	Dietetics		<input type="checkbox"/>	<input type="checkbox"/>	Sensory Impairment Supp.	
<input type="checkbox"/>	<input type="checkbox"/>	Elder Abuse Services		<input type="checkbox"/>	<input type="checkbox"/>	Shopping Assistance	
<input type="checkbox"/>	<input type="checkbox"/>	Emergency Response Support		<input type="checkbox"/>	<input type="checkbox"/>	Social/ Recreational	
<input type="checkbox"/>	<input type="checkbox"/>	Falls Prevention Exercise		<input type="checkbox"/>	<input type="checkbox"/>	Social Visiting	
<input type="checkbox"/>	<input type="checkbox"/>	Foot Care		<input type="checkbox"/>	<input type="checkbox"/>	Social Work	
<input type="checkbox"/>	<input type="checkbox"/>	Geriatric Mental Health CSS		<input type="checkbox"/>	<input type="checkbox"/>	Specialized Geriatric Services	
<input type="checkbox"/>	<input type="checkbox"/>	Group Dining		<input type="checkbox"/>	<input type="checkbox"/>	Substance Use/Gambling	
<input type="checkbox"/>	<input type="checkbox"/>	Health Promo & Education		<input type="checkbox"/>	<input type="checkbox"/>	Supports for Daily Living	
<input type="checkbox"/>	<input type="checkbox"/>	Home Help/Homemaking		<input type="checkbox"/>	<input type="checkbox"/>	Transportation	
<input type="checkbox"/>	<input type="checkbox"/>	Home Maintenance & Repair		<input type="checkbox"/>	<input type="checkbox"/>	Other:	
<input type="checkbox"/>	<input type="checkbox"/>	Hospice /Palliative Care		<input type="checkbox"/>	<input type="checkbox"/>	Other:	

### V. Functional, At-Risk Status

*In order to help us determine the services that may meet your needs. Please answer the following questions:*

**1. Do you live alone?** Yes No If no with whom: spouse relative friend child **Do you have someone who helps you?** Yes No

**2. Have you been hospitalized or in the Emergency Department in the last 3 months?** Yes No

**3. Do you have a family doctor?** Yes No **Have you seen a doctor within the last 6 months?** Yes No

**4. Have you had a fall in the last 3 months?** Yes No

**5. Have you lost or gained weight recently such that your clothes are not fitting?** Yes No

**6. Have you found that you have little interest or pleasure in doing things in the last month?** Yes No

**7. Are you or a family member concerned with your substance / alcohol use or gambling?** Yes No

**8. Have you noticed any changes in your memory?** Yes No

**9. Conditions / Diagnoses:** Are you currently being treated for any existing health issues?

- |  |   |   |                                      |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> Acquired brain injury | <input type="checkbox"/> Dementia/Alzheimer's | <input type="checkbox"/> Kidney disease                         | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Heart attack         | <input type="checkbox"/> Lung disease/emphysema/COPD            | <input type="checkbox"/> Stroke      |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Mental health or psychiatric condition | <input type="checkbox"/> Other:      |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Osteoporosis                           |                                      |

**10. Do you need help with your daily activities?** Yes No

**Functional independence (ADL):** Do you need help with any of the following:

- |                                   |   |                                    |
|-----------------------------------|---|------------------------------------|
| <input type="checkbox"/> Bathing  | <input type="checkbox"/> Eating           | <input type="checkbox"/> Transfers |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Using the toilet | <input type="checkbox"/> Other:    |

**Instrumental independence (IADL):** Do you need help with any of the following:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Accompaniment to appointments | <input type="checkbox"/> Meal preparation | <input type="checkbox"/> Shopping                             | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Housekeeping                  | <input type="checkbox"/> Laundry          | <input type="checkbox"/> Taking and or organizing medications | <input type="checkbox"/> Other:         |

**11. Special Instructions:**  Vision impaired  Hearing  Speech  Mobility aids (walker, wheelchair, bed/house bound)  In-home oxygen

Special circumstances (e.g. behavioural changes, aggression)  Requires caregiver support  Other:

**Additional information / comments on any risks identified above:**

**VI. MICBA Forum Italia Services**

We offer the following services based on assessment. Please check off the services that you feel you need.

<input type="checkbox"/> <b>Case Management</b> - advocacy, specialized case management for clients with mental health conditions, Alzheimer’s disease and dementia, supportive counseling and resource coordination.	<input type="checkbox"/> <b>Crisis Intervention, Support</b> – support and assistance for an individual in a crisis situation, or in need of assistance in coping with the daily demands of independent living.	<input type="checkbox"/> <b>Emergency Response Support</b> - services that provide electronic devices in a client’s home in order to enable communication with a centralized response centre and Forum Italia staff in an emergency.
<input type="checkbox"/> <b>Falls Prevention Exercise</b> – on-site group or 1:1 exercise program that provides gentle exercise for clients who are frail and have challenges with mobility. Designed to improve strength, conditioning and mobility.	<input type="checkbox"/> <b>Foot Care</b> - on-site chiropodist to help with the care and condition of feet including provision of health information and or treatment recommendations for all problems affecting the foot.	<input type="checkbox"/> <b>Health Promotion &amp; Education</b> - Education and information to optimize health for clients and caregivers. Services are aimed at enabling people to increase control over and to improve their health.
<input type="checkbox"/> <b>Home Help/Homemaking</b> - assistance at home with routine household activities including light housekeeping, laundry, and light meal preparation.	<input type="checkbox"/> <b>Home Maintenance &amp; Repair</b> - Repairs and maintenance to an individual’s home performed as needed and at the discretion of Forum Italia.	<input type="checkbox"/> <b>Personal Care/Support</b> – assistance with routine personal hygiene and other activities of daily living (such as bathing and dressing) based on individual need; training clients and or caregivers to carry out these activities.
<input type="checkbox"/> <b>Safety or Security Check</b> - A regular phone call or face-to-face visit in an client’s home to check on their safety and well-being.	<input type="checkbox"/> <b>Shopping Assistance</b> – assistance with shopping. Clients are responsible for the cost of their own food.	<input type="checkbox"/> <b>Social/ Recreational</b> – Social and recreational programs (such as: wellness programs, games, cultural events, outings, crafts and meals)
<input type="checkbox"/> <b>Social Visiting</b> –companionship and social connection through regular visits or phone calls from staff and or volunteers who are screened, trained and supervised.	<input type="checkbox"/> <b>Supports for Daily Living</b> - Personal care and support services. (such as: support services available on a 24 hour basis, medication monitoring, security checks, personal care or support)	<input type="checkbox"/> <b>Transportation</b> - Rides via company van for individuals who are unable to use public transportation to medical and social related appointments and or programs.

**Please fax completed form to the attention of Program Director (905) 507-3016.**