Regional Health Authority
Central Manitoba Inc.
Office régional de la santé
du Centre du Manitoba inc.

Facility / Home Care Coordinator Communication Tool

PART A

PART A

HOME CARE OFFICE: _____ COMMUNITY: _____

ORIGINATOR: _____ FACILITY CONTACT: _____

PHONE: _____ FAX: _____

WARD: _____ ADMISSION DATE: _____

ADMITTING DIAGNOSIS: _____

PART B

- CURRENT CARE PLAN

☐ HCA ☐ RN ☐ LPN ☐ RESPITE (PCH) ☐ ADULT DAY PROGRAM ☐REHAB. SERVICES ☐MOW ☐LIFE LINE

☐ OTHER (specify) _____

- PROVIDE BRIEF DESCRIPTION OF CARE PROVIDED/FREQUENCY OF ABOVE SERVICE, INCLUDING COPY OF EXERCISE PROGRAM:

_____

_____

_____

_____

- MEDICATION BLISTER PACK: ☐YES ☐NO
- FUNCTIONAL STATUS

  AMBULATORY: ☐YES ☐NO AID:_____ DISTANCE: _____

  METHOD OF TRANSFER: ☐INDEPENDENT ☐PIVOT TRANSFER ☐MECHANICAL LIFT
- CONTINENT : ☐YES ☐NO COMMENTS_____
- MENTAL STATUS: _____
- GERIATRIC ASSESSMENT COMPLETED: ☐Yes ☐No
- GERIATRIC SERVICES INVOLVED: ☐Yes ☐No

- EQUIPMENT & SUPPLIES

_____

_____

- LIVING ARRANGEMENTS PRIMARY CARE GIVER (NAME & PHONE NO.)

_____

- ☐ ALONE ☐BLOCK CARE ☐WITH OTHER (SPECIFY) _____
  ☐HOUSE ☐ONE STOREY ☐TWO STOREY ☐APARTMENT ☐EPH ☐ASST LIVING ☐OTHER
- LONG TERM CARE STATUS
  PANELLED: ☐Yes ☐No PANEL DATE: _____ DVA: ☐Yes ☐No
- ISSUES WHICH MAY IMPACT ON DISCHARGE:
  ☐HOME ACCESSIBILITY ☐RESISTANT TO CARE ☐FALL RISK ☐WANDERING
  ☐CONFUSION ☐FAMILY HAVING DIFFICULTY COPING ☐BEHAVIORAL CONCERNS
  ☐OTHER (SPECIFY)

  _____

  _____

OTHER PERTINENT INFORMATION AND/OR CONCERNS:

_____

_____