Manitoba Home Care Program
Basic Information Form

Manitoba Health

Home Care Number	
Date	Day / Month / Year
Co-ordinating Agency	

Client's Name (Surname) (Given Names)	Sex	Birthdate Day : Month : Year	Phone Number
Home Address			Postal Code

Band Name	Treaty Number	M.H.S.C. No.	Social Insurance No.

Region	Area	Can Person Communicate in English?	In Which Language Does Person Communicate Best?

Present Location: ☐ Same as Address ☐ Hospital ☐ Hostel ☐ Nursing Home ☐ Home of Relative ☐ Room and Board/Foster Home ☐ Other (specify)

Present Address	Postal Code

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced/Separated ☐ Other

Next of Kin or Person Responsible Name	Relationship	Phone Number
Address		Postal Code
Next of Kin or Person Responsible – Name	Relationship	Phone Number
Address		Postal Code

Person Making Referral:

Name	
Relationship/Agency	Phone Number
Address	Postal Code

What Major Problems were Presented by Person or Referree on Referral for Home Care:

Major (Check One Only)		Secondary (Check as Many as Applicable)	
☐ Illness	☐ Accident	☐ Illness	☐ Accident
☐ Advanced Age	☐ Social Situation	☐ Advanced Age	☐ Social Situation
☐ Other _____		☐ Other _____	

Comments from Referral Source (Describe above in more detail and indicate if person being referred knows about referral) _____

Physician's Name	Phone Number
Address	Postal Code

PLEASE TURN OVER TO COMPLETE.

MG-50 (Rev. 80)

Diagnosis:	Diagnosis Known	
Primary _____	To Family	To Person
Secondary _____	☐ Yes	☐ Yes
	☐ No	☐ No

Present Treatments and Medications: _____

Requested Treatments, Services, Equipment and Supplies: _____

Prognosis: ☐ A. Rehabilitation ☐ B. Maintenance at Present Level ☐ C. Deterioration Likely

General Comments Relative to Present Physical, Social and Emotional Levels of Functioning: _____

Community Services or Organizations Already Providing Service: _____

_____

Signature of Person Completing Form