HOME CARE
TRANSFER FORM – AGENCY TO AGENCY

Manitoba Health

TO: ______

FROM: ______

DATE OF TRANSFER: ______

PHIN: ______

CLIENT'S NAME SURNAME GIVEN NAMES	SEX	BIRTHDATE	PHONE NUMBER

HOME ADDRESS	POSTAL CODE

BAND NAME	TREATY NUMBER	MHSC NUMBER

REGION	AREA OFFICE	CAN PERSON COMMUNICATE IN ENGLISH? Yes No	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 ____	

MG-9828 (Rev. 03/06)

1. Ambulation

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

Reason: ____________________

Current Management: ____________________

Planned Intervention: ____________________

2. Elimination

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

Reason: ____________________

Current Management: ____________________

Planned Intervention: ____________________

3. Mental Status

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

Reason: ____________________

Current Management: ____________________

Planned Intervention: ____________________

4. Personal Care

Bathing

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

Reason: ____________________

Current Management: ____________________

Planned Intervention: ____________________

Dressing

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

Reason: ____________________

Current Management: ____________________

Planned Intervention: ____________________

4. Personal Care (continued)

Eating
_____ Independent
_____ Requires assistance or encouragement
_____ Independent with mechanical aids if food cup up
_____ 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
_____ Limited ability to make judgement
_____ Adequate for personal safety
_____ Unrealistic

Reason: ____________________

Current Management: ____________________

Planned Intervention: ____________________

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

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 ? individual spend his/her time? ____________________

____

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

____

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

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____

CARE PLAN AND GOALS (Summary)

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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					