THE GOOD SAMARITAN SOCIETY

DAY PROGRAM
REFERRAL FORM

South Ridge Village
550 Spruce Way SE, Medicine Hat, AB T1B 4P1
PH: (403) 528-5060
FX: (403) 504-2520

Client Name:			Date:	
Address: City: Postal Code:			Referred by: Organization: Org. Phone:	
Client Phone:			Home Care Case Coordinator: Coord. Phone:	
Personal Health Number:	Smoker: ☐ YES ☐ NO			
DOB:	Personal Directives - Yes/ No		Services:	
Religion:	Language spoken:		Frequency:	
Physician:	Phone:		Special Transit:	
Other Agencies Involved:		Agency Phone:	Contact:	

Contact Person	Relationship	Phone	Address	Postal Code
1.				
2.				

Reason for Referral:	☐ Regular ☐ Urgent **Preferred Days of Attendance:** Mon Tues Wed Thu Fri
Medical History / Diagnoses:	**Psychiatric History:** ☐ YES ☐NO (Explain)

Psychosocial Status: ☐Anxiety ☐Aggression ☐Suspiciousness ☐Agitation
(Explain)

Continuing Care Wait List: ☐Yes ☐No **(If yes)** ☐Regular ☐Urgent

Mantoux (TB) ☐Yes ☐No Date: **Result:**
Pneumovax ☐Yes ☐No Date:
Flu Vaccine ☐Yes ☐No Date:

Allergies ☐Yes ☐No List allergies:	**Medications** ☐Yes ☐No List medications:

☐Glasses	☐Hearing Aids	☐Dentures
☐Cane	☐Walker	☐Wheelchair #

Client Name: _____

I	MOBILITY	II	TRANSFERRING
1.	Independent	1.	Independent
2.	Minimal Assistance (Stand by)	2.	Minimal Assistance (Stand by)
3.	Moderate Assistance (1 person assistance)	3.	Moderate Assistance (1 person assistance)
4.	Full Assistance (2 person assistance)	4.	Full Assistance (2 person assistance)
III	**EATING**	**IV**	**TOILETING**
1.	Independent	1.	Independent
2.	Minimal Assistance (Tray Setup)	2.	Minimal Assistance (Walk to bathroom)
3.	Moderate Assistance (cut up food)	3.	Moderate Assistance (Stand by, monitoring)
4.	Full Assistance (tube feed or total feed)	4.	Full Assistance (Hands-on, clothing assist, cleaning, incontinent)
V	**SPECIAL NEEDS**	**VI**	**ELIMINATION**
1.	RN Treatment – Explain:	1.	Continent
2.	Foot Care	2.	Incontinent
3.	Bathing	3.	Incontinent – urinary (Requires assistance)
4.	Occupational Therapy – Explain:	4.	Incontinent – Fecal 9Requires assistance)
5.	Physical Therapy – Explain:		
VII	**NUTRITION**	**VIII**	**MENTAL STATUS**
1.	No Special Needs	1.	Alert
2.	Special Diet – Explain: LCS	2.	Minimal Confusion (some STM loss/needs minimal cueing
3.	Swallowing difficulties – Explain:	3.	Moderate Confusion following simple directions (needs moderate cueing)
4.	Tube Feeding – Explain:	4.	Maximum Confusion (cannot follow directions and difficulty verbalizing needs)
IX	**WANDERING**	**X**	**SOCIAL INTERACTION**
1.	Never	1.	Able to interact with individuals in a Group
2.	Occasional (needs redirection 1 – 2 times)	2.	Minimal Encouragement needed to participate and stay involved
3.	Most times (throughout the day)	3.	Moderate encouragement to get involved (must act repeatedly)
4.	Actively Attempts to Leave Comments:	4.	Needs 1 to 1 attention RT Comments:

GENERAL COMMENTS:

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_____

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_____ _____

Signature of Assessor Date

I agree to allow release of information to my physician, community agencies, or other disciplines who may be involved in my care at the present time or at a later date.

_____ _____

Client Signature or Legal Guardian Date