



Community Living Dufferin

Date Received _____

29 Centennial Road, Units 7 – 14
Orangeville, ON L9W 1R1
(519) 941-8971 Fax: (519) 941-9121
www.communitylivingdufferin.ca

APPLICATION AND INTAKE FOR ADULT SERVICES

Residential Programs:

- 8 Hours of Support Daily
- 24 Hours of Support Daily
- Prader Willi Treatment Program
- Transitional Living Co-operative (TLC)
- Supported Independent Living (SIL)
- Family Home
- Would you like some other type of Residential Support?

Day Programs:

- QPAC (Piecework)
- Employment Plus: Community/Volunteer Work
- Options Learning and Leisure Program

Needing Service: <input type="radio"/> IMMEDIATELY <input type="radio"/> Within 1 yr. <input type="radio"/> Within 3 yrs. <input type="radio"/> 3 + years

APPLICANT INFORMATION:

Name of Applicant: _____

Current Address: _____

City: _____ Postal Code: _____

Telephone: _____ E-mail: _____

Date of Birth: _____ ODSP: _____

Social Insurance: _____ Health Card: _____

NEXT OF KIN

Name: _____ Relationship to Applicant: _____

Address: _____

City: _____ Postal Code: _____

Tel: (Home): _____ Telephone (Work): _____

E-mail: _____

MEDICAL

Diagnosis: _____

General Health: _____

Special Conditions: _____

Name of Physician: _____

Address: _____

City: _____ Postal Code: _____

Telephone: _____ E-mail: _____

Is Applicant on any prescription medication? YES NO

If YES, please specify: Self-administered Assisted

Medication	Dosage	Frequency	Time

Does Applicant have any allergies? YES NO

If YES, please specify: FOOD MEDICATION ENVIRONMENT

Describe (include reaction / course of action):

Does Applicant have seizures? YES NO CONTROLLED

Frequency: _____

Type: _____

Physical Signs: _____

Approximate Duration: _____

After Effects: _____

Does Applicant have any chronic health problems which should be noted? YES NO

If YES, please explain: _____

Does Applicant have any health problems which would limit / restrict certain activities?

YES NO If YES, please explain: _____

Has this person been hospitalized within the last year?

YES NO If YES, please explain: _____

SPECIAL SERVICE REQUIREMENTS (please specify)

Please indicate involvement with services listed below and provide name and phone number. Also indicate (Yes/No) if a report was generated

- Physiotherapist _____ report? _____
Name number
- P/W Specialist (i.e.: Dr. Beral)
_____ report? _____
Name number
- Dietician _____ report? _____
Name number
- Psychiatrist _____ report? _____
Name number
- Psychologist _____ report? _____
Name number
- Occupational Therapist _____ report? _____
Name number
- Speech Therapist _____ report? _____
Name number
- Behaviour Therapist _____ report? _____
Name number
- Other _____ report? _____
Name number

Does Applicant require services of any other health/physician specialists?

YES NO If YES, please specify:

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: _____ Ext: _____ E-mail: _____

Speciality: _____

Reason: _____

Length of Time in Care: _____

OTHER INFORMATION (please complete only those sections that apply)

Dentures	Yes / No	Braces	Yes / No
Other Health Device (Specify)		Date of Last Physical Exam	
Date of Last Eye Exam		Date of Last Hearing Test	
Date of Last Inoculation		Date of Last Tuberculosis Test	

Sleeping Patterns:

Normal Wanders Needs Assistance

Details: _____

Menstrual Cycle:

Normal Irregularities Associated Difficulties Needs Monitoring/Assistance

Details: _____

Motor Skills/ Mobility:

Independent Transfer Assistance Wheel Chair dependent Mobility Aids

Full Use of Limbs Partial Use of Limbs (Specify) _____

Details: _____

Vision:

Normal Impaired Blind (record CNIB Registration #): _____

Wears Glasses/Contacts (describe) _____

Details: _____

Hearing:

Normal Impaired Deaf Uses Hearing Aids: Left Ear Right Ear

Details: _____

Care of Hearing Aid / Eyeglasses:

Independent Training Needed Not Physically Able Needs Assistive Devices

Heart Disease / High Blood Pressure:

Please describe history, diagnosis and present limitations: _____

Usual blood pressure (if known): _____ Blood Type: _____

Fungus Infections / Athletes Foot:

Describe usual medications and / or treatment: _____

Fainting Spells:

Describe treatment: _____

Diabetes:

Controlled by: Diet (attach copy) Oral medication Insulin (frequency) _____

Glucometer Readings (frequency) _____ Range of sugar levels: _____

Amount of assistance needed: _____

Describe signs of Hypo/Hyper Glycemia: _____

Asthma:

Describe treatment, limitations and medications: _____

Dental Health: Seeing Dentist: Regularly Infrequently Never Anxious About Going*
(*Is medication required?)

Dentist Name: _____

Address: _____ City: _____

Postal Code: _____ Phone: _____

FUNCTIONING LEVEL / SKILLS

- Borderline Mild Moderate Profound Severe
- Verbal Non Verbal Uses Sign language Uses Communication devices
- Able to Read Able to Write Number Recognition Handles Money

Has there been a recent psychological assessment: Yes / No?
Please provide specifics ie. Date / Results / IQ

Details: _____

Receptive Language:

- Understands Most Things Well Understands Some Words / Phrases
- Follows Instruction (Examples)

Details: _____

SOCIAL FUNCTIONING

Behaviours: (select all that apply)

- Gets along well with: Peers Females Males
- No behaviour issues Limited social skills Adjusts easily to new situations
- Physically Aggressive Verbally Aggressive Needs sexuality training
- Other: Explain _____

Cooperation: Always Usually Never

Details: _____

Attention Span: Short Periods Medium Periods Long Periods

Details: _____

Motivation:

Self-initiated Needs Some Encouragement Needs Prompting Not Motivated

Details: _____

Frustration Tolerance: Good Easily Upset (describe behaviour)

Details: _____

SKILLS

Personal Hygiene:

Independent Training Needed Not Physically Able Needs Assistive Devices

Details: _____

Toileting:

Independent Training Needed Not Physically Able Needs Assistive Devices

Details: _____

Eating:

Independent Training Needed Not Physically Able Needs Assistive Devices
 Special Diet

Details: _____

Smoker:

Is this person a smoker? Yes / No? Describe smoking habit, program etc. _____

Bathing:

Independent Training Needed Not Physically Able Needs Assistive Devices

Details: _____

Cooking:

- Independent Training Needed Not Physically Able Needs Assistive Devices

Details: _____

Laundry:

- Independent Training Needed Not Physically Able Needs Assistive Devices

Details: _____

Dressing:

- Independent Training Needed Not Physically Able Needs Assistive Devices

Details: _____

Community Use: (Transit)

- Independent Training Needed Not Physically Able Needs Assistive Devices

Details: _____

Home Maintenance: (Give Examples)

- Independent Training Needed Not Physically Able Needs Assistive Devices

Details: _____

FAMILY / CAREGIVER STATUS

- Lives with:** Parents One parent Siblings Friends/roommate
 Relatives' Independently Significant family involvement Minor family involvement
 No family involvement Unknown Other

Explain Other: _____

EDUCATION PROGRAMS

School Attended Last:

Address: _____

Dates Attended From: _____ To: _____

SPECIAL INTERESTS / SKILLS

COMPLETED BY

Name: _____ Date: _____

Telephone: _____ E-mail Address: _____

Agency: (if applicable): _____

Relationship to Applicant: _____

Addendum for Respite / Prader Willi Home

Prader Willi Group Home – Regional Beds

BEHAVIOURS

Does applicant have access to money: Yes No

Do they spend it responsibly? _____

Does applicant over-use products: i.e.: shampoo, laundry soap etc. Yes No

Describe: _____

Obsession over routines or objects: Yes No

Describe: _____

Food Seeking:

Is the home environment secured in terms of access to food? Yes No

If yes, please explain restrictions: (locked fridge, cupboards etc.) _____

Does applicant seek food from...

neighbouring houses garbage cans shoplifting stealing from others

Details: _____

Does applicant eat inedibles such as shampoo, deodorant, laundry soaps etc.? Yes No

Details: _____

Verbal Aggression:

Describe: _____

Physical Aggression:

Describe: _____

What are your expectations of Community Living Dufferin?

What is the applicants' expectation of Community Living Dufferin?

COMPLETED BY

Date: _____

Name: _____

Telephone: _____

E-mail Address: _____

Agency: (if applicable): _____

Relationship to Applicant: _____