NORTHERN HEALTH REGION

HOME CARE DISCHARGE/REFERRAL FORM

DATE: _____ *Addressograph*

Allergies: _____

Diagnosis: _____

Known to person: ☐ Yes ☐ No

Known to family: ☐ Yes ☐ No

Medications: _____

_____

_____

_____

_____

_____

Compliance: ☐ Good ☐ Poor

Ability to Administer: ☐ Able ☐ Unable

Diet: _____

_____

Daily Living:

Lives: ☐ Alone ☐ With someone

Is client / family member able to:

Prepare meals: ☐ Yes ☐ No

Do housekeeping: ☐ Yes ☐ No

Do shopping: ☐ Yes ☐ No

Additional concerns: _____

Services Recommended:

☐ Nursing (dressing changes, medications etc.)

☐ Home Care Attendant (assist with bath)

☐ Equipment ☐ Supplies ☐ Teaching

☐ Other (please specify) _____

_____

Ambulation:

Aides: ☐ none ☐ cane ☐ walker ☐ wheelchair

Level of Independence:

☐ independent ☐ one person assist

☐ two person assist ☐ completely dependent

Transferring:

☐ independent ☐ one person assist

☐ two person assist ☐ completely dependent

Continence:

☐ completely continent

☐ self catheterizes

☐ incontinent - urine

☐ occasionally ☐ always

☐ incontinent - feces

☐ occasionally ☐ always

☐ colostomy

☐ independent ☐ assist

Mental Status:

☐ completely orientated

☐ mildly confused / occasionally disorientated

☐ mildly confused / always disorientated

☐ moderately confused / occasionally disorientated

☐ moderately confused / always disorientated

☐ markedly confused / always disorientated

☐ depressed ☐ anxious ☐ bizarre behaviour

Personal Care:

Bathing: ☐ self ☐ assist ☐ complete

Dressing: ☐ self ☐ assist ☐ complete

Toileting: ☐ self ☐ assist ☐ complete

Feeding: ☐ self ☐ assist ☐ complete

Client/Patient Contact Information:

Client's Name:_____

Address:_____

Phone:_____

Expected Discharge Date: _____

Contact Person Information:

Contact Person's Name:_____

Phone:_____

Alternate Phone: _____

Relationship to Client:_____

Nurse's Signature: _____ Date: _____