Community Therapy Services

Support & Consultation for Independent Living SCIL

Application for Occupational Therapy Services

APPLICANT INFORMATION:

Name:_____ _____
(surname) (given names)

Address: _____ Postal Code:_____

Phone: _____ Cell / Alt #: _____ Email:_____

DOB: _____ Age: _____ ☐ M ☐ F ☐ R ☐ L
(d/m/y) (dominant hand)

MHSC #: _____ PHIN #: _____ EIA #:_____

REFERRAL INFORMATION:

What is the reason for this application?

☐ Eviction (currently without housing)
☐ At risk of eviction
☐ Difficulties in current living situation
☐ Planning to move to more independent housing
☐ Assessment of capacity to live independently
☐ Assessment of capacity to manage finances
☐ Cognitive issues
☐ Other: _____

Expected Move Date
(if applicable):

_____

What are your specific areas of concern regarding independent living skills?

☐ Personal Care
☐ Managing Medications
☐ Household Management
☐ Laundry
☐ Other: _____

☐ Nutrition / Menu planning
☐ Cooking
☐ Shopping
☐ Managing Money

☐ Using Public Transit
☐ Community Access
☐ Structuring my Day
☐ Safety

Please describe your concerns: _____

_____

_____

Have you or do you experience difficulties in the following areas?

☐ Memory ☐ Organization ☐ Decision-making
☐ Problem-solving ☐ Attention / concentration ☐ Reading / Writing

Please explain: _____

_____

PERSONAL INFORMATION:

Relationship Status:

☐ Single ☐ Married ☐ Common Law
☐ Separated ☐ Divorced ☐ Widowed
☐ Other

Do you have young children? ☐ *Yes* ☐ *No* *If yes, number / ages:*_____
Are they in your care? ☐ *N/A* ☐ *Yes* ☐ *No*

_____

Living Situation:

☐ Alone ☐ With spouse / partner ☐ Young children at home
☐ With adult children ☐ With parent / grandparent ☐ With roommate
☐ Residential Care Facility ☐ Homeless / Shelter ☐ Other: _____

How long have you lived at your current address? _____

Where did you live previously? _____

If not currently living alone, have you ever lived on your own? ☐ *Yes* ☐ *No* ☐ *N/A*

Do you have pets? (if yes, explain: _____) ☐ *Yes* ☐ *No*

Education:

☐ < Grade 6 ☐ < Grade 9 ☐ Partial High school
☐ High School / GED ☐ Trade school ☐ College / University

Employment Status:

☐ Employed: PT ___ FT ___ ☐ Unemployed ☐ Homemaker
☐ Volunteering ☐ Student ☐ Retired

Income Sources (check all that apply):

☐ Work income ☐ Family ☐ Savings / inheritance
☐ EIA ☐ EIA Disability ☐ CPP Disability
☐ GST rebate ☐ Shelter Benefit / Rent Aid ☐ Portable Housing Benefit
☐ Can. Pension Plan (CPP) ☐ Old Age Security (OAS) ☐ Guaranteed Income Sup. (GIS)
☐ Private Disability/Pension ☐ Other: _____

Management of Affairs:

☐ Self
☐ Public Trustee (finances)
☐ Family (informal)
☐ Public Trustee (finances / healthcare)
☐ Private Power of Attorney (POA)
☐ Other: _____

HEALTH INFORMATION:

Mental Health Diagnoses (check all that apply & place * beside primary diagnosis):

☐ Anxiety disorder
☐ Bipolar disorder
☐ Depression
☐ Eating disorder
☐ Hoarding disorder
☐ OCD
☐ Personality disorder
☐ PTSD
☐ Psychosis - NOS
☐ Schizo-affective disorder
☐ Schizophrenia
☐ Other: _____

Cognitive / Neurodevelopmental Diagnoses (check all that apply):

☐ ADHD
☐ Autism/PDD
☐ Brain injury (date: _____)
☐ FASD
☐ Cognitive disorder - NOS
☐ Dementia
☐ Intellectual disability
☐ Mild cognitive impairment
☐ Other: _____

Have you or do you experience the following problems?

☐ Agitation
☐ Anger
☐ Anxiety/panic
☐ Confusion
☐ Depressed mood
☐ Excessive spending
☐ Feeling hopeless/worthless
☐ Hallucinations
☐ Hoarding
☐ Lack of meaningful activity
☐ Lack of motivation
☐ Negative thinking
☐ Physical aggression
☐ Self harm behaviour
☐ Sleep difficulties
☐ Social withdrawal/isolation
☐ Unusual thoughts/ideas
☐ Verbal aggression

Please explain: _____

_____

Have you experienced suicidal thoughts or behaviour? ☐ *Yes* ☐ *No*

If yes, please explain: _____

_____

How frequently do you use the following mental health services?

Mental health crisis line	☐ Never	☐ Rarely	☐ Occasionally	☐ Frequently
Mobile crisis unit	☐ Never	☐ Rarely	☐ Occasionally	☐ Frequently
Crisis stabilization unit	☐ Never	☐ Rarely	☐ Occasionally	☐ Frequently
Crisis response centre	☐ Never	☐ Rarely	☐ Occasionally	☐ Frequently
Other: _____	☐ Never	☐ Rarely	☐ Occasionally	☐ Frequently

Have you been hospitalized for mental health reasons? ☐ *Yes* ☐ *No*

If yes, when/where was your most recent admission? _____

Physical Health Concerns (check all that apply):

☐ Chronic fatigue	☐ Fibromyalgia	☐ Physical limitations
☐ Chronic pain	☐ Mobility issues	☐ Seizure disorder
☐ Diabetes	☐ Obesity	☐ Allergies: _____
☐ Other: _____	☐ Other: _____	☐ Other: _____

Please describe how these concerns affect day-to-day functioning: _____

_____

Medications (please list):

☐_____	☐_____
☐_____	☐_____
☐_____	☐_____
☐_____	☐_____

Do you take your medications regularly as prescribed?	☐ *Yes*	☐ *No*
Do you have problem with medication side effects?	☐ *Yes*	☐ *No*
Have you had any recent changes to your medications?	☐ *Yes*	☐ *No*

If yes to any of the above, please explain: _____

_____

OTHER INFORMATION:

Are any of the following applicable to you (check all that apply)?

☐ Smoking	☐ History of being abused
☐ Problem alcohol use	☐ History of aggressive/violent behaviour
☐ Substance use	☐ Involvement with criminal justice system
☐ Problem gambling	☐ Bedbugs
☐ Recent significant loss or change	☐ Other: _____

If yes to any of the above, provide details: _____

_____

Languages spoken: ☐ English ☐ Other _____

Is language or culture a concern or barrier for you?	☐ *Yes*	☐ *No*

If yes, please explain: _____

Is there a WRHA Safe Visit Plan?	☐ *Yes*	☐ *No (no safety risks identified)*
(If so, include with referral)	☐ *Unknown*	☐ *No (SAFT/SVP not completed)*

SUPPORT / CONTACT INFORMATION:

Check all that apply and provide name and phone number:

designation:	*name:*	*phone number:*
☐ Psychiatrist	_____	_____
☐ Family Physician	_____	_____
☐ Mental Health Worker	_____	_____
☐ Homecare Coordinator	_____	_____
☐ EIA Worker	_____	_____
☐ Public Trustee / POA	_____	_____
☐ Family contact	_____	_____
☐ Other: _____	_____	_____

Referral Source:

☐ **Referral made by applicant:**

How did you learn about SCIL? _____

Were you assisted to fill out this form? ☐ *Yes* ☐ *No*

If yes, by whom? _____

Note: You must provide at least one health care contact in the list of contacts above.

Applicant Signature: _____ ***Date:*** _____

☐ **Referral made by Health Care Provider:**

Name & designation: _____ Phone:_____

Address: _____ Fax:_____

Is client aware of and in agreement with referral? ☐ *Yes* ☐ *No*

Note - If available, please indicate and include the following with referral:

☐ Previous OT report(s) ☐ Other applicable reports/documentation

Signature:_____ ***Date:*** _____

please return application to:
Community Therapy Services
101 - 1555 St. James St.
Winnipeg, MB R3H 1B5
Ph: (204) 949-0533 Fax: (204) 942-1428