



Community Therapy Services
Support & Consultation for Independent Living

SCIL

OFFICE USE ONLY
Date Rec'd: _____
Coding: ____, ____, Screened by: _____
Date Acpt'd: _____

Application for Occupational Therapy Services

APPLICANT INFORMATION:

Name: _____
(surname) (given names)

Address: _____ Postal Code: _____

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

DOB: _____ Age: _____ Gender Identity:
(d/m/y) F _____
 M Prefer not to say

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?

- | | | |
|---|--|---|
| <input type="checkbox"/> Personal Care | <input type="checkbox"/> Nutrition / Menu planning | <input type="checkbox"/> Using Public Transit |
| <input type="checkbox"/> Managing Medications | <input type="checkbox"/> Cooking | <input type="checkbox"/> Community Access |
| <input type="checkbox"/> Household Management | <input type="checkbox"/> Shopping | <input type="checkbox"/> Structuring my Day |
| <input type="checkbox"/> Laundry | <input type="checkbox"/> Managing Money | <input type="checkbox"/> Safety |
| | | <input type="checkbox"/> Other: _____ |

Please describe your concerns: _____

PERSONAL INFORMATION:

Relationship Status:

- | | | |
|------------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Single | <input type="checkbox"/> Married | <input type="checkbox"/> Common Law |
| <input type="checkbox"/> Separated | <input type="checkbox"/> Divorced | <input type="checkbox"/> Widowed |
| | | <input type="checkbox"/> Other: _____ |

Do you have young children in your care? Yes No

If yes, number / ages: _____

Living Situation (check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Alone | <input type="checkbox"/> With spouse / partner | <input type="checkbox"/> Residential Care Facility |
| <input type="checkbox"/> With adult children | <input type="checkbox"/> With parent / grandparent | <input type="checkbox"/> With roommate |
| <input type="checkbox"/> Young children at home | <input type="checkbox"/> Homeless / Shelter | <input type="checkbox"/> Pets(describe): _____ |
| | | <input type="checkbox"/> 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

If Yes, when? _____

Education:

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> < Grade 6 | <input type="checkbox"/> < Grade 9 | <input type="checkbox"/> Partial High school |
| <input type="checkbox"/> High School / GED | <input type="checkbox"/> Trade school | <input type="checkbox"/> College / University |

Employment Status:

- | | | |
|--|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Employed: PT ___ FT ___ | <input type="checkbox"/> Unemployed | <input type="checkbox"/> Homemaker |
| <input type="checkbox"/> Volunteering | <input type="checkbox"/> Student | <input type="checkbox"/> Retired |

Income Sources (check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> Work income | <input type="checkbox"/> Family | <input type="checkbox"/> Savings / inheritance |
| <input type="checkbox"/> EIA | <input type="checkbox"/> EIA Disability | <input type="checkbox"/> CPP Disability |
| <input type="checkbox"/> GST rebate | <input type="checkbox"/> Shelter Benefit / Rent Aid | <input type="checkbox"/> Portable Housing Benefit |
| <input type="checkbox"/> Can. Pension Plan (CPP) | <input type="checkbox"/> Old Age Security (OAS) | <input type="checkbox"/> Guaranteed Income Sup. (GIS) |
| <input type="checkbox"/> Private Disability/Pension | <input type="checkbox"/> Other: _____ | |

Management of Affairs:

- | | | |
|--|---|--|
| <input type="checkbox"/> Self | <input type="checkbox"/> Public Trustee (finances only) | <input type="checkbox"/> Private Power of Attorney (POA) |
| <input type="checkbox"/> Family (informal) | <input type="checkbox"/> Public Trustee (finances/healthcare) | <input type="checkbox"/> Other: _____ |

HEALTH INFORMATION:

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Hoarding disorder | <input type="checkbox"/> Psychosis - NOS |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> OCD | <input type="checkbox"/> Schizo-affective disorder |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Personality disorder | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> PTSD | <input type="checkbox"/> Other: _____ |

Cognitive / Neurodevelopmental Diagnoses (check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> FASD | <input type="checkbox"/> Intellectual disability |
| <input type="checkbox"/> Autism/PDD | <input type="checkbox"/> Cognitive disorder - NOS | <input type="checkbox"/> Mild cognitive impairment |
| <input type="checkbox"/> Brain injury (date: _____) | <input type="checkbox"/> Dementia | <input type="checkbox"/> Other: _____ |

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Memory | <input type="checkbox"/> Organization | <input type="checkbox"/> Decision-making |
| <input type="checkbox"/> Problem-solving | <input type="checkbox"/> Attention / concentration | <input type="checkbox"/> Reading / Writing |

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 | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Frequently |
| Mobile crisis unit | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Frequently |
| Crisis stabilization unit | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Frequently |
| Crisis response centre | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Frequently |
| Other: _____ | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Occasionally | <input type="checkbox"/> 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):

- | | | |
|--|---|---|
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Mobility issues | <input type="checkbox"/> Allergies: _____ |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Obesity | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Physical limitations | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Other: _____ |

Medications (please list):

<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
<input type="checkbox"/>	_____	<input type="checkbox"/>	_____

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):

- | | |
|--|---|
| <input type="checkbox"/> Smoking | <input type="checkbox"/> History of being abused |
| <input type="checkbox"/> Problem alcohol use | <input type="checkbox"/> History of aggressive/violent behaviour |
| <input type="checkbox"/> Substance use | <input type="checkbox"/> Involvement with criminal justice system |
| <input type="checkbox"/> Problem gambling | <input type="checkbox"/> Bedbugs |
| <input type="checkbox"/> Recent significant loss or change | <input type="checkbox"/> 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: _____

SUPPORT / CONTACT INFORMATION: (* Required information)

Check all that apply and provide name and phone number:

<i>Designation:</i>	<i>*Name:</i>	<i>*Phone/*Fax numbers:</i>
<input type="checkbox"/> Psychiatrist	_____	_____ / _____
<input type="checkbox"/> Family Physician	_____	_____ / _____
<input type="checkbox"/> Mental Health Worker	_____	_____ / _____
<input type="checkbox"/> Homecare Coordinator	_____	_____ / _____

<input type="checkbox"/> EIA Worker	_____	_____ / _____
<input type="checkbox"/> Public Trustee / POA	_____	_____ / _____
<input type="checkbox"/> Family contact	_____	_____ / _____
<input type="checkbox"/> Other: _____	_____	_____ / _____

REFERRAL INFORMATION:

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: _____

Email: _____

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

**Is there a WRHA Safe Visit Plan?
(If so, include with referral)**

Yes No (no safety risks identified)
 Unknown No (SAFT/SVP not completed)

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

Previous OT report(s) Other applicable reports/documentation

Signature: _____

Date: _____

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