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

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: _____ (d/m/y) Age: _____ Gender Identity: ☐ 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?

- ☐ Personal Care
- ☐ Managing Medications
- ☐ Household Management
- ☐ Laundry
- ☐ Nutrition / Menu planning
- ☐ Cooking
- ☐ Shopping
- ☐ Managing Money
- ☐ Using Public Transit
- ☐ Community Access
- ☐ Structuring my Day
- ☐ Safety
- ☐ Other: _____

Please describe your concerns: _____

_____

_____

PERSONAL INFORMATION:

Relationship Status:

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

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

Living Situation (check all that apply):

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

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

HEALTH INFORMATION:

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

- ☐ 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 difficulties in the following areas?

- ☐ Memory
- ☐ Problem-solving
- ☐ Organization
- ☐ Attention / concentration
- ☐ Decision-making
- ☐ 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	☐ 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
- ☐ Chronic pain
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Mobility issues
- ☐ Obesity
- ☐ Physical limitations
- ☐ Seizure disorder
- ☐ Allergies: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

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

Designation:	**Name:*	**Phone/*Fax numbers:*
☐ Psychiatrist	_____	_____ / _____
☐ Family Physician	_____	_____ / _____
☐ Mental Health Worker	_____	_____ / _____
☐ Homecare Coordinator	_____	_____ / _____

☐ EIA Worker _____ _____ /_____

☐ Public Trustee / POA _____ _____ /_____

☐ Family contact _____ _____ /_____

☐ 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? ☐ *Yes* ☐ *No (no safety risks identified)*
(If so, include with referral) ☐ *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