CLIENT INTERVENTION AND SUPPORT SERVICES (CISS) INTAKE FORM

If completed by Agency staff, please fax this form to 905-830-5023. Any questions, please call 1-877-464-9675 ext. 73433.

***Please note that this form must be printed clearly and completed fully for processing.**

Person Completing Form:	Date Intake Form Completed (dd/mm/yyyy):

A. PERSONAL INFORMATION

Client's Name: ______________________________

Street Address: ______________________________ Apartment #:____________

City: ______________________________ Postal Code: ____________

Home Phone #: ____________ Cell Phone #: ____________ Best time to call: _________

OK to leave message? ☐ Yes ☐ No

Language: ☐ English ☐ Other: ______________________

Gender: ☐ F ☐ M DOB (dd/mm/yyyy): ___________ Age: ________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated/Divorced

Living Arrangement: ______________________________

B. REFERRAL SOURCE

Name: ______________________________ Phone#: ______________________________

Fax #: ______________________________

☐ Self ☐ Partner/Spouse ☐ Family Member ☐ Caregiver ☐ CCAC ☐ *GOT **(please attach GOT assessment if available)*

☐ Agency/Other: ______________________________

C. **CONSENT FOR INTAKE**			
The Regional Municipality of York (York Region) needs your permission to collect, use and disclose personal and health information for the purposes of planning and providing services. York Region will need to share the collected information amongst its partners and authorized staff. Your information is private. Unless sharing is permitted by law, York Region will not give out your information without your consent. Do you understand and give consent to this?			
Verbal consent received from Client or Substitute Decision Maker.		☐ YES	☐ NO
Consent Provided By:	Relationship to Client:		

D. ALTERNATE CONTACTS – If we cannot reach you, who should we call.

Name: ____ Relationship to Client: _____________

Phone #: _________________________ Cell Phone #: ________________________

Type of Contact: ☐ Primary Contact to arrange services ☐ Caregiver ☐ Emergency Contact ☐ Translator

☐ Substitute Decision Maker ☐ Power of Attorney – Property ☐ Power of Attorney – Personal Care

Name: ____ Relationship to Client: _____________

Phone #: _________________________ Cell Phone #: ________________________

Type of Contact: ☐ Primary Contact to arrange services ☐ Caregiver ☐ Emergency Contact ☐ Translator

☐ Substitute Decision Maker ☐ Power of Attorney – Property ☐ Power of Attorney – Personal Care

Family Doctor's Name: ___________________________ Phone #: _________________ Fax #: ________________

☐ Unknown ☐ N/A

E. REASON FOR REFERRAL: (What assistance do you require from the Social Worker?)

F. BRIEF FUNCTIONAL ASSESSMENT

1. **Health Status:**

Have you gone to the emergency department in the past year? ☐ Yes ☐ No If yes, how many times? _____
Reason:_____________________________________

Have you been admitted to the hospital in the past year? ☐ Yes ☐ No If so, when? _______________
Reason: ____________________________________

Have you had any recent falls? ☐ Yes ☐ No If yes, how many? __________
Reason: ____________________________________

2. **Social Support**

Are you socially active? E.g. with family, friends, faith community or service clubs? ☐ Yes ☐ No

If yes, please describe: ____

3. **Functional Independence (ADL): Do you need help with any of the following:**

Bathing ☐ Yes ☐ No ☐ Unknown
Dressing ☐ Yes ☐ No ☐ Unknown
Eating ☐ Yes ☐ No ☐ Unknown
Toileting ☐ Yes ☐ No ☐ Unknown
Foot Care ☐ Yes ☐ No ☐ Unknown
Mobility ☐ Yes ☐ No ☐ Unknown

(If Yes, please list aids used) ____

4. **Instrumental independence (IADL): Do you need help with any of the following:**

Meal Preparation	☐ Yes	☐ No	☐ Unknown
Laundry	☐ Yes	☐ No	☐ Unknown
Managing Money/Finances	☐ Yes	☐ No	☐ Unknown
Housekeeping	☐ Yes	☐ No	☐ Unknown
Transportation	☐ Yes	☐ No	☐ Unknown
Medication Management	☐ Yes	☐ No	☐ Unknown

5. **Do you need help with anything else (e.g. shopping, going to the doctor's office, arranging appointments, etc.)?**

☐ Yes ☐ No (If Yes, please state) ____

6. **Do you have any of the following health conditions:**

Arthritis	☐ Yes	☐ No	☐ Unknown	**Heart attack**	☐ Yes	☐ No	☐ Unknown
Cancer	☐ Yes	☐ No	☐ Unknown	**Heart disease**	☐ Yes	☐ No	☐ Unknown
Diabetes	☐ Yes	☐ No	☐ Unknown	**High blood pressure**	☐ Yes	☐ No	☐ Unknown
Memory problems	☐ Yes	☐ No	☐ Unknown	**Kidney disease**	☐ Yes	☐ No	☐ Unknown
On Oxygen	☐ Yes	☐ No	☐ Unknown	**Osteoporosis**	☐ Yes	☐ No	☐ Unknown
Parkinson's	☐ Yes	☐ No	☐ Unknown	**Mental health**	☐ Yes	☐ No	☐ Unknown
				(if Yes, please specify)	____________________		
Lung disease/Asthma				**Stroke**	☐ Yes	☐ No	☐ Unknown
Emphysema/COPD	☐ Yes	☐ No	☐ Unknown	**Other**	____________________		

Are you taking any medications for the above conditions? ☐ Yes ☐ No

7. **Do you have any of the following impairments?**

Visual ☐ Yes ☐ No ☐ Unknown| **Hearing** ☐ Yes ☐ No ☐ Unknown |**Speech** ☐ Yes ☐ No ☐ Unknown

Comments: ____

G. SERVICE INFORMATION

Are you currently receiving any other services? ☐ Yes ☐ No

If yes, Agency Name: ☐ CCAC ☐ CHATS ☐ YSSN ☐ CMHA ☐ Veteran's Affairs

☐ Alzheimer's Society ☐ Geriatric Outreach Team ☐ IPOP ☐ Adult Day Program

☐ Other: Please Specify ____

Are you currently on a wait list for services? ☐ Yes ☐ No
If yes, please specify ____ Agency Name:__________________

Do you have an existing case manager or other agency contact information? ☐ Yes ☐ No

If yes, Name/Agency: ____ Phone # ______________________

Are you currently on a wait list for a long-term care facility? ☐ Yes ☐ No

H. ENVIRONMENTAL CONSIDERATIONS

Pets	☐ Yes	☐ No	☐ Unknown
Smoking	☐ Yes	☐ No	☐ Unknown
Contagious Illness	☐ Yes	☐ No	☐ Unknown
Other	___________________________		

I. Additional Comments/Special Instructions:

Signature of
Person Completing Form: ________________________________ Date (dd/mm/yyyy): ________________