Community Support Services Client Intake Form

(Please Print)

Program code:	**LHIN code:**

CLIENT INFORMATION

Client's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐Miss ☐ Ms.	Marital status (circle one) ☐Single☐Mar ☐ Div☐ Sep☐ Wid

Birth date: / /	Age:	Sex: ☐ M ☐ F	Pets: ☐ Yes ☐ No	☐Cats/☐dogs/☐other(list)	Number of pets:

Household size:	Related clients:

Street address:	City:	Postal Code:
Unit Number:	Entry code/instructions for access:	Phone no:
911 address:	Business number :	Cell:

Are you aware there is a fee for service? ☐ Yes ☐ No	Billing Reference Number (if applicable):

Billing Contact (DVA, Alzh's, ODSP, etc...)	Contact name:	Address:	Phone no:

EMERGENCY CONTACT INFORMATION

Emergency Contact 1

Contact's last name: First: Middle:		
Relationship to client:	Billing Contact: ☐ Yes ☐ No	
Street address:	City:	Postal Code:
Unit Number:	Entry code:	Phone no:
911 address:	Business number:	Cell:

Emergency Contact 2

Contact's last name: First: Middle:		
Relationship to client:	Billing Contact: ☐ Yes ☐No	
Street address:	City:	Postal Code:
Unit Number:	Entry code:	Phone no:
911 address:	Business number:	Cell:
Family Physician:	Phone no:	

AUTHORIZATION FOR SERVICE (IF REQUIRED)

Signature	*Date*

Transportation Services Intake Form

CLIENT DEMOGRAPHICS	
Sensitivities/allergies:	Infectious Disease/Screening:
History of Falls: ☐Yes ☐No	Health Considerations/behaviors of which Red Cross should be aware of?
Accommodations (i.e. house, apartment, senior's residence):	

Living Arrangements:	☐ Alone	☐ Caregiver	☐Other	☐Roommate	☐With Children	☐Friend	☐Other Residents	☐Parents	☐Relative	☐Spouse

French Language Service:	Languages:	
Reason for Service Request:	Referral Source:	Backup plan in case Red Cross can't provide service:

MOBILITY EQUIPMENT INFORMATION						
☐No mobility devices used	☐ Walker	☐ Rollator Walker	☐Cane	☐Manual Wheelchair	☐Electric Scooter	☐Electric W/C

Seat Belt Exemption: ☐Yes ☐No	Documents:	
Chair Equipped with Seatbelt: ☐Yes ☐No	Client requires RC transfer chairs: ☐Yes ☐ No	Self-transfers to vehicle seat: ☐Yes ☐ No
Client Enters Vehicle Without Assistance: ☐ Yes ☐No		

Client requires:	☐Door to Door	☐Hand to Hand	☐Curb to Curb
Escort Travels with Client: ☐Yes ☐No		Relationship to client:	
Client Requires Medical Oxygen: ☐ Yes ☐ No	Oxygen Type:	☐POC	☐Cylinder

Client Requires Service Animal: ☐Yes ☐No	Evidence of Vaccination Records: ☐ Yes ☐No	Evidence of Animal Credentials: ☐ Yes ☐ No

FUNDING INFORMATION		
End of Funding Date:	Subsidy Rate Requested: ☐ Yes ☐No	Funding Rate:
Details:	Authorization Period for Funding:	

FOR OFFICE USE ONLY								
Trip Types:	☐Adult Day	☐Banking	☐Compassionate	☐ Dialysis	☐Medical	☐Shopping	☐Social	☐Therapy

Emergency Response Level: ☐ERL1	☐ERL2	☐ERL3		
Contingency Plan:	☐Client did not provide	☐Call emergency contacts	☐Client will use cab	☐Other:
Type of Vehicle Required:	☐Accessible Bus	☐Non-Accessible Bus	☐Accessible Van	☐Non-accessible van	☐Cars (RC/personal)

FORM COMPLETION		
Date:	Completed By:	Authorization Signature: