CLIENT PROFILE

File Assessment/ Intake Date : Time:

Person Callling:

Thorold / St. Catharines CIMS# **K#**

Client Name:	**Phone:**
Address:	**Postal Code:**
Delivery Instructions:	
Marital Status: *S M W D Sep* Other:	**Ethnic Origin:**
Date of Birth	**( )**
Reason for Requiring Meals (Client words):	
Other Services?	

SECTION B. SCREENER DATE:

VERBAL CONSENT: Y/N **UPLOAD CONSENT: Y/N** **REFERRAL CONSENT: Y/N** **SCREENED BY: BP**

1. COGNITIVE SKILLS FOR DAILY DECISION MAKING: 0. Independent 1. Modified independent or impairment ☐

2. ACTIVITIES OF DAILY LIVING: 0. Independent or set-up help only OR 1. Supervision or any physical assistance

a. BATHING ☐ **c. DRESSING LOWER BODY** ☐

b. PERSONAL HYGIENE ☐ **d. LOCOMOTION** ☐

3. DYSPNEA (SHORTNESS OF BREATH):

0. Absence of symptom 1. Absent at rest, but present when performed moderate activities

2. Absent at rest, but present when performed normal day-to-day activities 3. Present at rest ☐

4. SELF-REPORTED HEALTH: 0. Excellent 1. Good 2. Fair 3. Poor 8. Could not (would not) respond ☐

5. INSTABILITY OF CONDITIONS: 0. NO 1. YES

a. Conditions. diseases make cognitive, ADL, mood, or behavior patterns unstable ☐

b. Experiencing an acute episode, or a flare-up of a recurrent or chronic problem ☐

6. SELF-REPORTED MOOD: Ask: *"IN THE LAST 3 DAYS have you felt sad, depressed, or hopeless?*

0. NO 1. YES 8. COULD NOT (WOULD NOT) RESPOND ☐

7. INFORMAL HELPER STATUS: 0. No 1. Yes

a. Primary informal helper expresses feelings of distress, anger, or depression ☐

b. Family or close friends report feeling overwhelmed by person's illness ☐

Other Food Sources: *Shop for Self Grocery Delivery Homemaker Family Help Congregate Dining Other:*

Living Arrangements: *Alone Spse Fam Frnd* **Accommodation:** *House Apt Other*	**Pets?** *Yes No* Kind:	**Microwave?** *Yes No* **Stove Use Hazard?** *Yes NO*

IN CASE OF EMERGENCY			
1. Name:	**Address:**		
Home #:	**Work #:**	**Cell #:**	**Rltnshp:**
2. Name:	**Address:**		
Home #:	**Work #:**	**Cell #**	**Rltnshp**
PROGRAMS:	**MOW: HOT:** *M T W R F*	**Source:** *Shaver IGG*	**FROZEN: # /WK**
	QUIK PAK: #	*Soup or Dessert JUICE*	

DIET: *Food Allergies?*	*Intolerances?*	*Food Dislikes?*	**DIET TYPE:**

FOOD ALLERGIES:	**Dr. Diagnosed** *Yes No*	**Reactions/Symptoms:**
MOW ADMISSION DATE:		**REASON:**
Referred By:	**Referred To:**	
RED FLAGS / SPECIAL NEEDS/Other needs Identified:		
Payment: *Cash / Chq* **BILL:**	**CLIENT /OTHER**	**VA ELIGIBLE: Y/N**
K#	**VA approval #**	**per week / hot or cold**
CASEMANAGER:		
Background: (*ie: financial/cultural)/Comments/Follow-up*:		

SERVICE CHECKLIST:

Interviewed By:____ _____ EXPLAINED TO: *Client / Family / Other:* _____

Registration Fee X❒	Hot Delivery Schedule X❒	Frozen Delivery Schedule ❒X
Hot Meal Composition X❒	Cancellation Policy X❒	Storm Delivery Cancellation X❒
Fees/Billing Procedure X❒	Trays Microwave only X❒	Stat Holiday Procedure X❒
	Nutritional Screening X❒	Lunch Out X❒

Entered into CIMS: ❒ By whom_____

NEW CLIENT PACKAGE Given to Client/Ecp: __ _ Dated: _____ ___

SECTION C. SUMMARY

1. ASSESSMENT URGENCY ALGORITHIM SCORE ☐

2. interRAI CHA ASSESSMENT REQUIRED (0. NO 1. YES) ☐