Community Care Northumberland

CLIENT REGISTRATION FORM

SECTION 1 - PRIMARY INFORMATION		
Date of first contact:	Staff Person:	
Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.		
Last Name:	First Name:	Initial:
Health Card #:	DOB:	Gender:
Address:		
Postal Code:	P.O. Box:	
Home Phone:	Other Phone:	

SECTION 2 - IAR RECORD SEARCH

Non-Screener Programs: *(no IAR search or Preliminary Screener required, proceed to Section 3)*

☐ Community Diners ☐ Home Help/ Home Maintenance ☐ Other:
☐ Hospice Palliative Care ☐ Falls Prevention and Exercise

Screener Programs: *(IAR search and screener or full assessment required)*

☐ Friendly Visiting ☐ Meals On Wheels ☐ Supports for Caregivers
☐ Telephone Security Checks ☐ Transportation – Specialized ☐ Transportation - Volunteer

IAR Record search results:

☐ No record found - *Preliminary Screener required*
☐ Record found, assessment type and date: ____
  ☐ Greater than 1 year old – *new Preliminary Screener is required*
  ☐ Less than 1 year old – *no Preliminary Screener is required*

SECTION 3 - REGISTRATION INFORMATION

HOME ENVIRONMENT INFORMATION	
Special instructions: *(directions to home, buzzer number, which door to use, beware of dog, etc.)*	
Living arrangements: (*alone or others in home)*	
Type of residence: *(single family, apartment, condo, etc.)*	
Accessibility issues in residence: *(stairs, ramp, etc.)*	
Language(s) spoken:	
Are there pets in the residence?	
Is there oxygen in the residence?	
Is there smoking in the residence?	
EMERGENCY CONTACT INFORMATION	
Name:	Name:
Relationship:	Relationship:
Home Phone:	Home Phone:
Other Phone:	Other Phone:

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POWER OF ATTORNEY – PROPERTY	POWER OF ATTORNEY – PERSONAL CARE
Name:	Name:
Relationship:	Relationship:
Home Phone:	Home Phone:
Business Phone:	Business Phone:
OTHER AGENCY/ COMMUNITY SUPPORT	**BILLING**
Organization:	Organization:
Address:	Address:
Contact:	Contact:
Phone:	Phone:
Comments:	Comments:

HEALTH INFORMATION			
	YES	**NO**	**DETAILS**
Main Illness/ Health Concerns			
Cognitive Impairment			
Hearing Impairment			
Speech Impairment			
Vision Impairment			
Mobility Impairment			
Respiratory Concerns			
Smoker			
Allergies			
Primary Health Care Provider:			**Phone:**

SECTION 4 - CLIENT ACKNOWLEDGEMENT

Community Care Northumberland cannot assume liability for private arrangements made without the knowledge and approval of the office. I understand I must always call the Community Care office to request service.

I understand that Community Care is an organization providing service generally by volunteers, who although are dedicated, caring people, are not necessarily experts in their field of service, therefore I waive any claim or cause of action whatsoever, including any claim for injury or damage of any kind against Community Care, its volunteers, employees and trustees, arising from negligence of Community Care, its volunteers, employees and trustees, or from any other cause.

Signature of Client: ____ Date: __________________________

Or verbal consent obtained on: ______________________________

Signature of Staff Completing: ______________________________