27 Forest Street, Parry Sound, Ontario P2A 2R2

# APPLICATION FORM

Name: ______________________________________ Date: _____________________

Address: ___________________________________________________________________

____________________________________________ Postal Code: _______________

Telephone (Home): ___________________________ (Work): ___________________

Ontario Health Card No: _______________________ Date of Birth: ______________

Primary Disability/Medical Condition: __________________________________________

Other Medical Conditions (if any): ____________________________________________

1. **Living Arrangement:**

Alone ❍ Spouse ❍ Children ❍ Other ❍

2. What other agencies/care-givers assist you:
(e.g. Home Care, family members)?

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

3. **What services do you require from *The Friends'* Program?** (Please indicate days, times as well as the assistance you require).

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

4. **Please complete the following chart:**

| | Independent | Requires Assistance |
|---|---|---|
| Arising & Going to Bed | | |
| Dressing | | |
| Toiletting/Bowel & Bladder Routines | | |
| Bathing | | |
| Managing Personal Hygiene (hair combing, brushing teeth, etc.) | | |
| Cooking Meals | | |
| Laundry & Housekeeping | | |
| Shopping | | |

5. **Do you feel your medical condition is:** (Please check one)

Stable ❍ Deteriorating ❍

Fluctuating ❍ Improving ❍

6. **Alternate Contacts:** (Next of Kin, POA, Case Manager, Caregiver, etc.):

Name Relationship Telephone #

_______________ _______________ _______________

_______________ _______________ _______________

_______________ _______________ _______________

7. **Consent:**

I, ______________________ give my permission to ***THE FRIENDS'*** Management Team to contact the people listed above with regards to my medical and personal care needs if required.

Client Signature: ______________________ Date: ______________

Witness: ______________________ Date: ______________

Caregiver/Substitute Decision Maker: ______________ Relationship: __________

Serving East / West Parry Sound and Muskoka

27 Forest Street, Parry Sound, Ontario P2A 2R2

**MEDICAL INFORMATION FORM**

## INSTRUCTIONS:

1) To be completed by the family physician
2) The information provided is used to assist in determining your eligibility to *The Friends* and developing appropriate care services for the applicant.
3) Any charge for completion of this form is the responsibility of the applicant.

## RELEASE:

I, ______________________________, consent to the release of my medical information to *The Friends.*

______________________________________ ____________________________

Signature Date

______________________________________ ____________________________

Witness Date

## DEMOGRAPHICS:

1) Patient Name: ______________________________________ Date of Birth: ______________________

## DISABILITY:

2) Diagnosis of main disabling condition

3) Current treatments for this condition

4) Prognosis

5) Comments

## FUNCTIONAL ASSESSMENT:

Please help us determine the applicant's level of functioning and aid needs

| | Yes | No |
|---|---|---|
| Visual impairments | ☐ | ☐ |
| Speech impairments | ☐ | ☐ |
| Hearing impairments | ☐ | ☐ |
| Mobility impairments | ☐ | ☐ |
| Cognitive impairments | ☐ | ☐ |

Other: ______________________________________________________________

_________________ _________________________ ________________________

Date Physician's Name Physician's Signature

Physician's Address: ___________________________________________________________________

Phone #: ____________________________________