



**WENDAT PSYCHOGERIATRIC PROGRAM
MOBILE SOCIAL WORK INTAKE FORM**

**Referred by:
Organization name and address:**

Date of Referral: _____

Referral Contact:

Name: _____

Phone #: _____

Fax # _____

Client Information:

Client name: _____

DOB: _____ HC# _____

Marital

Address: _____

Status _____

Gender: Man Women

I identify as _____

Phone: _____

Language first spoken _____

Language of communication: _____

Aboriginal origin: Y N U/K

Veteran: Y N U/K

Cultural Needs: Y N U/K specify _____

Spiritual Needs: Y N U/K specify _____

Is this person Capable for:

Personal Care/Treatment: Y N U/K

Property: Y N U/K

Contact Person

Contact Person

(Name and relationship))

(Name and relationship)

(Address)

(Address)

(Telephone)

(Telephone)

Alternate Contact Person: _____

(Name)

(Telephone)

(Address)

(Relationship)

Is the person aware of this referral? Y N U/K _____

Has consent been obtained? Y N U/K _____

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History of Hospitalizations: (This refers to total # of **previous** admissions)

Psychiatric: Diagnoses: _____

Psychiatrist: _____ Mental Health Worker: _____

Medical: # of admissions ____ Date of last admission/assessment: _____

Diagnoses: _____

Family Physician: _____

(Name)

(Address)

(Telephone)

Medications: (Prescribed, OTC and Herbal): **Please Attach**

Allergies: _____

Falls Risk Assessment completed? Y N **Result:** _____

REASONS FOR REFERRAL TRIAGE TOOL

CRITICAL FACTORS

Areas of assessed risk/concern:

- Harm to self/other Abuse/neglect
- Repeat E.D. visits Recent psych admit/diagnosis
- Increased substance use Complicated grief/loss

Issues related to accessing services outside their home?

YES NO

- Transportation Mobility Complicated health issues Caregiving issues

Is the client living alone?

YES NO

Compounding factors – risk of increased frailty?

YES NO

- Co-morbidity Impaired mobility Weakness Vision loss
- Weight loss Hearing loss Cognitive issues Mood issues
- Substance Abuse Advanced age 75+ Poverty Legal issues
- Caregiver stress Social/Geographical isolation Behavioural issues Housing/environmental
- Other _____

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POSSIBLE SUPPORTIVE FACTORS

Supports/resources activated:

YES NO

- Formal care in place
- Informal – family/friends
- Caregiver involvement
- Extended Health coverage
- Social connection
- Environmental/housing
- Other

Previous involvement or eligibility with a support service:

YES NO

- Waypoint PG Outreach
- GDH
- Alzheimer Society 1st Link
- CCAC SW
- Community Mental Health
- Family Health Team SW
- ABI
- Chaplain/Priest
- Hospice
- Veterans Affairs
- CHC
- Red Cross/ SW
- SASOT
- MST
- Other

Other services/supports better able to help meet the needs/goals:

YES NO

- Waypoint PG Outreach
- GDH
- Alzheimer Society 1st Link
- CCAC/ SW
- Community Mental Health
- Family Health Team
- ABI
- Chaplain/Priest
- Hospice
- Veterans Affairs
- CHC
- Red Cross /SW
- SASOT
- MST
- Other _____

Referrer's comments: As a result of your assessment and interventions to date and in obtaining consent for this referral:

What has the prospective client verbalized as his/her goals for further Social Work involvement?

What other referrals have you made? (Continue on next page if needed)

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Thank you for assisting us in assuring that the service we provide is effective, efficient and appropriate to the needs of our mutual client as well as their formal and informal support system.

Please forward this completed 4-page Social Work intake form to:

Zina Thomson, RPN

Program Supervisor

Wendat Community Programs

44 Dufferin St. Penetanguishene, ON L9M 1H4 FAX: (705) 355-1026

WEBSITE : www.wendatprograms.com

The Program Supervisor can also be reached by telephone

Monday to Friday 9AM - 5PM at (705) 355 - 1022 Ext. 228

For Wendat office use:

Pre-Screening Result: Priority level determined Further Screening Needed

Comments/recommendations:

Post-screening Result:

- Priority High – response required in approx. 2-4 weeks (+ or - depending on SW availability)
- Priority Medium - response likely in approx 1-2 months (+ or - depending on SW availability)
- Priority Low – response when/if HR available (seek other potential resources)
- Consultative/System Navigation
- Not appropriate for this service

Comments/recommendations:

Completed By: _____

Date: _____