



**A & O: SUPPORT SERVICES FOR OLDER ADULTS
THIS FULL HOUSE REFERRAL FORM**

200 – 280 SMITH ST. WINNIPEG, MB R3C 1K2
PHONE: (204) 956-6440 FAX: (204) 946-5667
EMAIL: intake@aosupportservices.ca

DATE: _____ REFERRING AGENCY: _____

REFERRAL NAME: _____ REFERRAL PHONE NO.: _____

CLIENT(S) NAME: _____ D.O.B. (M/D/Y): _____

ADDRESS : _____

POSTAL CODE: _____ PHONE NO.: _____

TYPE OF DWELLING: _____ OWN/RENT: _____

INCOME SOURCE(S): _____

HOUSEHOLD MEMBERS: _____

PETS/ANIMALS: _____

FAMILY OR OTHER SUPPORTS (NAMES AND PHONE NUMBERS): _____

OTHER AGENCIES/PROGRAMS INVOLVED (HOME CARE, PSYCHIATRIST, HOSPITAL STAFF,
PUBLIC TRUSTEE, ETC.): _____

PHYSICAL/MENTAL HEALTH STATUS OF CLIENT: _____

WILL CLIENT ALLOW ACCESS TO THEIR HOME ? _____

WE ARE CURRENTLY OFFERING THE BURIED IN TREASURES WORKSHOP (SEE FAQ ON
WEBSITE). IS CLIENT INTERESTED IN PARTICIPATING IN THIS WORKSHOP?:

PLEASE COMPLETE THE RISK ASSESSMENT ON THE FOLLOWING PAGE.



THIS FULL HOUSE RISK ASSESSMENT

RISK FACTOR	LOW RISK		HIGH RISK			DESCRIPTION
	1	2	3	4	5	
EVICTION	1	2	3	4	5	HIGHER RISK IF: NOTICE HAS BEEN GIVEN, HISTORY OF EVICTIONS, SHORT TIMEFRAME
HOSPITAL DISCHARGE	1	2	3	4	5	DOES DISCHARGE DEPEND ON LIVING CONDITION OF HOME? IS CLIENT DEPENDENT ON SERVICES POST DISCHARGE?
TERMINATION OF SERVICES	1	2	3	4	5	E.G. HOME CARE NO LONGER ABLE TO PROVIDE SERVICES DUE TO CONDITION OF HOME
FINES, ORDERS FROM CITY OFFICIALS	1	2	3	4	5	IF HOME HAS BEEN PLACARDED = 5
INFESTATIONS	1	2	3	4	5	TYPE AND DEGREE OF INFESTATION, DANGER PRESENT TO CLIENT
MENTAL OR PHYSICAL HEALTH BARRIERS	1	2	3	4	5	E.G. MENTAL OR PHYSICAL DISABILITIES, INSIGHT
EXISTING SUPPORTS	1	2	3	4	5	INFORMAL AND FORMAL SUPPORTS

OTHER SAFETY OR HEALTH CONCERNS:



A & O: SUPPORT SERVICES FOR OLDER ADULTS

**THIS FULL HOUSE
CONSENT FOR RELEASE OF INFORMATION**

I, _____ GIVE PERMISSION TO _____
(CLIENT NAME) *(REFERRAL NAME)*

OF _____ TO SHARE INFORMATION WITH A&O: SUPPORT
(REFERRAL AGENCY)

SERVICES FOR OLDER ADULTS IN ORDER TO DETERMINE ELIGIBILITY FOR THE 'THIS FULL HOUSE' PROGRAM.

I ALSO AGREE THAT THE FOLLOWING INFORMATION MAY BE SHARED (AT CLIENT'S REQUEST) WITH THE FOLLOWING ORGANIZATIONS FOR THE PURPOSE STATED BELOW:

<u>INFORMATION</u>	<u>ORGANIZATION</u>	<u>PURPOSE</u>
<i>E.G.: ADVISING OF REFERRAL</i>	<i>WRHA (HOME CARE)</i>	<i>- CARE PLAN CAN BE UPDATED</i>

ADDITIONAL COMMENTS/REMARKS:

CLIENT SIGNATURE: _____ DATE: _____

WORKER SIGNATURE: _____ DATE: _____

IF VERBAL CONSENT IS GIVEN PLEASE COMPLETE THE FOLLOWING:

DATE: _____ REFERRAL SOURCE SIGNATURE: _____