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

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
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:

_____

_____

_____

_____

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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:

INFORMATION	ORGANIZATION	PURPOSE
E.G.: ADVISING OF REFERRAL	*WRHA (HOME CARE)*	*- CARE PLAN CAN BE UPDATED*

ADDITIONAL COMMENTS/REMARKS:

_____

_____

_____

_____

CLIENT SIGNATURE: _____ DATE: _____

WORKER SIGNATURE: _____ DATE: _____

IF VERBAL CONSENT IS GIVEN PLEASE COMPLETE THE FOLLOWING:

DATE: _____ REFERRAL SOURCE SIGNATURE: _____