Community Step Up Program form

Referral information

Referral date * ______________________

Organization name * ______________________

Contact name * ______________________

Contact number * ______________________

Email * ______________________

Client/SDM approved referral * ◯ Yes ◯ No

Client information

Client name * ______________________

Gender * ◯ Male ◯ Female

DOB * ______________________

Email ______________________

Contact number * ______________________

City * ______________________

Street address * ______________________

Language * ______________________

Postal code * ______________________

If required: substitute decision maker information

SDM name ______________________

Day time number ______________________ ☐ Same as client contact

Alternate number ______________________

Email ______________________

Street address ______________________ ☐ Same as client contact

City ______________________

Postal code ______________________

Preferred language ______________________

Medical information

Primary care physician * ______________________

Fax number * ______________________

Phone number * ______________________

Overall health concerns

- ☐ Balance
- ☐ Strength
- ☐ Range of motion
- ☐ Gait/Ambulation
- ☐ Acute Injury/event (sprain, fracture, cardiac, neuro)
- ☐ Post-operative
- ☐ High risk for falls / post fall
- ☐ Pain
- ☐ Needs support with ADLs
- ☐ Fine motor skills
- ☐ Home safety
- ☐ Coughing while eating or taking longer to eat meals
- ☐ Making modification to their foods or avoiding certain foods
- ☐ History of acid reflux
- ☐ Gradual or sudden change in their communication
- ☐ Difficulty understanding what the client is saying (not related to ESL)
- ☐ Difficulty finding their words

Chronic conditions

- ☐ Alzheimer's/Dementia
- ☐ Asthma
- ☐ Cardiac
- ☐ Diabetes
- ☐ Stroke
- ☐ Other
- ☐ Arthritis
- ☐ Cancer
- ☐ COPD
- ☐ Neurological (ALS, MS, Parkinson's)
- ☐ Shortness of breath

Considerations for the program

Does the client suffer with incontinence? * ◯ Yes ◯ No

Does the client need assistance with toileting? * ◯ Yes ◯ No

Does the client have responsive behaviours? * ◯ Yes ◯ No

Does the client have impulsivity? * ◯ Yes ◯ No

Is there any history of violence? * ◯ Yes ◯ No

Other concerns * ______________________