Client Information Form

St. Paul's Community Services and Housing
3333 Finch Avenue East, Scarborough, Ontario M1W 2R9 Tel: 416-493-3333

St. Paul's programs and services are subsidized by the government; the following data are collected for the purposes of reporting, program planning, and communicating with you. The information on this form is strictly confidential and is solely intended for the authorized use set out by St. Paul's Privacy of Information Policy.

General

General			Client Tracking #
Client Lastname			Firstname
Home Phone		Cellular Phone	
Address		Unit	City
Postal Code	buzz # (if any)	☐ Own ☐ Rent	Email Address

Gender	**Birthdate**	**Health Card No.** Including version code
☐ Male ☐ Female	MM DD YYYY	☐☐☐☐-☐☐☐-☐☐☐ ☐☐

Language	Mother Tongue	Country of Origin
If not English, do you understand English?	☐ Yes ☐ No	

Living Arrangement:	
☐ Lives Alone	
☐ Lives with:	

Type of Accommodation					
☐ House	☐ Townhouse	☐ Condominium/Apartment			
☐ LTC Facility	☐ Retirement Home	☐ Senior Apartment			
☐ St. Paul's Rental	☐ St. Paul's Terrace	☐ Wishing Well			

Marital Status			
☐ Never Married	☐ Divorced		
☐ Married	☐ Separated		
☐ Widowed	☐ C. Law/Partner		

Referral Source:									
☐ CCAC	☐ Church	☐ Community Agency	☐ Family / Relative	☐ Friend / Neighbour					
☐ Hospital	☐ Media	☐ Professional / Therapist	☐ Staff	☐ Other:					
Referrer's Name:				Phone No:					
External Service Currently Received:									

Service Request

Please check the service you are interested in：

☐	Caregiver Support Group	☐	Client Intervention
☐	Congregate Dining Service	☐	Day Program
☐	Friendly Visiting	☐	Health & Wellness
☐	Home Support	☐	Meals on Wheels
☐	Recreation	☐	Support Group
☐	Transportation	☐	Volunteer Support
☐	Other:		

For Housing Applicant only:	
☐	Rental - Bachelor with kitchen
☐	Rental- Bachelor without kitchen
☐	Rental - 1 bedroom
☐	Life Equity - 1 bedroom
☐	Life Equity - 2 bedrooms

Diagnosis

Mobility Status	
☐	Fully Ambulatory
☐	Cane
☐	Walker
☐	Wheelchair
☐	Scooter
Transfer:	
☐	Independent
☐	One Assistant
☐	Two Assistants

Health Status							
☐	Alzheimer	☐	Arthritis	☐	Asthma	☐	Cancer
☐	Dementia	☐	Depression	☐	Diabetes	☐	Heart Disease
☐	High Cholesterol	☐	Hypertension	☐	Osteoporosis	☐	Parkinson
☐	Stroke/TIA's	☐	Allergies (please list)				
Other							
					Smoker	☐ Yes ☐ No	
					Alcohol	☐ Yes ☐ No	

Comments

Most recent hospital admission:	Date:	Hospital:
Reason:		

Contacts

Family Physician

Lastname	Firstname	Phone:

Emergency Contact #1

Lastname	Firstname	Relationship to client
Address:		Postal Code
Home Phone:	Cellular Phone:	Business Phone:
Email Address:		
☐ Power of Attorney for Personal Care	☐ Power of Attorney for Property and Finances	

Emergency Contact #2

Lastname	Firstname	Relationship to client
Address:		Postal Code
Home Phone:	Cellular Phone:	Business Phone:
Email Address:		
☐ Power of Attorney for Personal Care	☐ Power of Attorney for Property and Finances	

Form completed by (Please Print): _____

Signature: _____ Date: _____