Intake and Admission Package

Nnenia Extended Care Services, Inc.

Location:
115147 27 & 28 Sideroad
Grand Valley, Ontario L0N 1G0

INTAKE FACESHEET

CLIENT INFORMATION:

Name of Client Supported:		
Client Date of Birth/Age:		
Gender:		
Address:		
Home Phone # / Mobile #:		
Languages Spoken:		
Religion:		
Cultural Practices:		
Name of School and Grade / Equivalent (if applicable):		
Family Physician / Phone #:		
Allergies:		
Family Member / Guardian	Name:	
	Relationship:	
	Contact Information:	
Sending Agency:	Agency Name:	
	Case Manager:	
	Contact Information:	
Emergency Contact:	Name:	
	Relationship:	
	Contact Information:	
Restricted Contacts:		

REASON FOR REFERRAL TO NNENIA EXTENDED CARE SERVICES, INC.:

SERVICES REQUIRED (Residential, Respite, Day Program)

BRIEF SUMMARY OF NEEDS (Please forward all previous assessments, behaviour support plans, client profiles, and/or care plans):

MEDICAL CONCERNS:

CURRENT MEDICATIONS:

ADMISSION PACKAGE

PERSONAL CARE	NEED	ACTION	RESPONSIBLE	TARGET DATE	REVIEW DATE
HYGIENE	BATH EQUIPMENT				
BATH	Method Sponge: Tub: Shower:				
SHAVING					
MOUTH CARE					
SKIN CARE					
DRESSING					
ELIMINATION	INCONTINENCE				
PERICARE	Bladder: Bowel:				
TOILETING	Equipment Aids:				

PERSONAL CARE	NEED	ACTION	RESPONSIBLE	TARGET DATE	REVIEW DATE
MOBILITY	EQUIPMENT / MOBILITY AIDS				
WALKING	Cane: Walker:				
AMBULATION	Crutches: Wheelchair:				
CLIENT SAFETY	Hospital Bed:				
TRANSFERS	Independent: x1 Assist: x2 Assist: Mechanical Lift:				
NUTRITION	MEAL / GROCERIES				
FEEDING	Independent: Parent/Family: Meals on Wheels: Other: Aids:				

PERSONAL CARE	NEED	ACTION	RESPONSIBLE	TARGET DATE	REVIEW DATE
NUTRITION	MEAL / GROCERIES				
MEAL PREPARATION					
SPECIAL DIET ALLERGIES					
COMMUNICATION					
IMPAIRED					
SPEECH					
HEARING					
VISION					
COMPREHENSION	**AIDS:**				
MEDICATION REMINDERS					
CARE REQUIREMENTS					
SUPPORTS	Parent: Spouse: Family: None:				

PERSONAL CARE	NEED	ACTION	RESPONSIBLE	TARGET DATE	REVIEW DATE
HOUSEKEEPING					
LIGHT CLEANING					
LAUNDRY					
CHANGE BEDDING					
OTHER ACTIVITIES AND CARE NEEDS					

BEHAVIOURAL ASSESSMENT

How would you describe the individual's **temperament**? Please check all that apply.

☐ Timid ☐ Friendly ☐ Happy ☐ High-strung ☐ Moody

☐ Quiet ☐ Anxious ☐ Sensitive ☐ Aggressive ☐ Nervous

Other: _____

Are there any behavioural concerns the staff should know about? ☐ Yes ☐ No

If yes, please check any of the following that the individual does:

☐ Breath holding	☐ Undue lethargy	☐ Rocking	☐ Soil eating
☐ Nervousness	☐ Persistent lying	☐ Head-banging	☐ Stealing
☐ Twitching/tics	☐ Thumb sucking	☐ Pinching	☐ Nail-biting
☐ Disrobing	☐ Yelling/shouting	☐ Aggression	☐ Isolation
☐ Biting	☐ Easily distracted	☐ Spitting	☐ Overactivity
☐ Hitting	☐ Pulls out own hair	☐ Depressed	☐ Inattentive
☐ Argumentative	☐ Damage to property	☐ Bed wetting	☐ Running away
☐ Throwing objects	☐ Swearing	☐ Verbal threats	☐ Smearing feces

Self-injury (specify): _____ Other: _____

What are the concerns and what are the causes for these behaviour(s)?

Best way to approach the individual:

Strategies for behaviour management (de-escalation strategies):

ENVIRONMENTAL TRIGGERS

☐ Is not triggered by loud noises
☐ Is bothered when touched by others
☐ Is bothered/sensitive to bright lights
☐ Can be startled easily
☐ Is triggered by loud noises. Responds by: _____
☐ Does not adapt well to change: _____

CHECKLIST: Please mark any of the following in each area that describes the client:

RELATING TO OTHER PEOPLE

☐ Prefers to be by self
☐ Aloof, distant
☐ Fearful of strangers
☐ Would rather be in groups
☐ "In a world of his/her own"
☐ Clings to people
☐ Will initiate conversation
☐ Will not initiate, but would engage in conversation

RESPONSE TO SOUNDS, SPEECH

☐ Often ignores sounds
☐ Afraid of certain sounds
☐ Often ignores what is said to him/her
☐ Really likes certain sounds (music, motors etc.)
☐ Seems to hear distant or soft sounds that most other people don't hear or notice
☐ Unpredictable response to sounds (sometimes reacts, sometimes doesn't)

VISUAL RESPONSE

☐ Stares vacantly around the room
☐ Often doesn't look at things
☐ Likes to look at self in mirror
☐ Distracted by lights – stares at certain lights
☐ Very interested in small parts of an object
☐ Looks at things out of the corners of eyes

EMOTIONAL RESPONSES

☐ Temper tantrums (Mood changes quickly)
☐ Overly responds to situations
☐ Cries/seems sad for no obvious reason
☐ Laughs/smiles for no obvious reason
☐ Often has blank facial expression
☐ Little response to what is happening around him/her

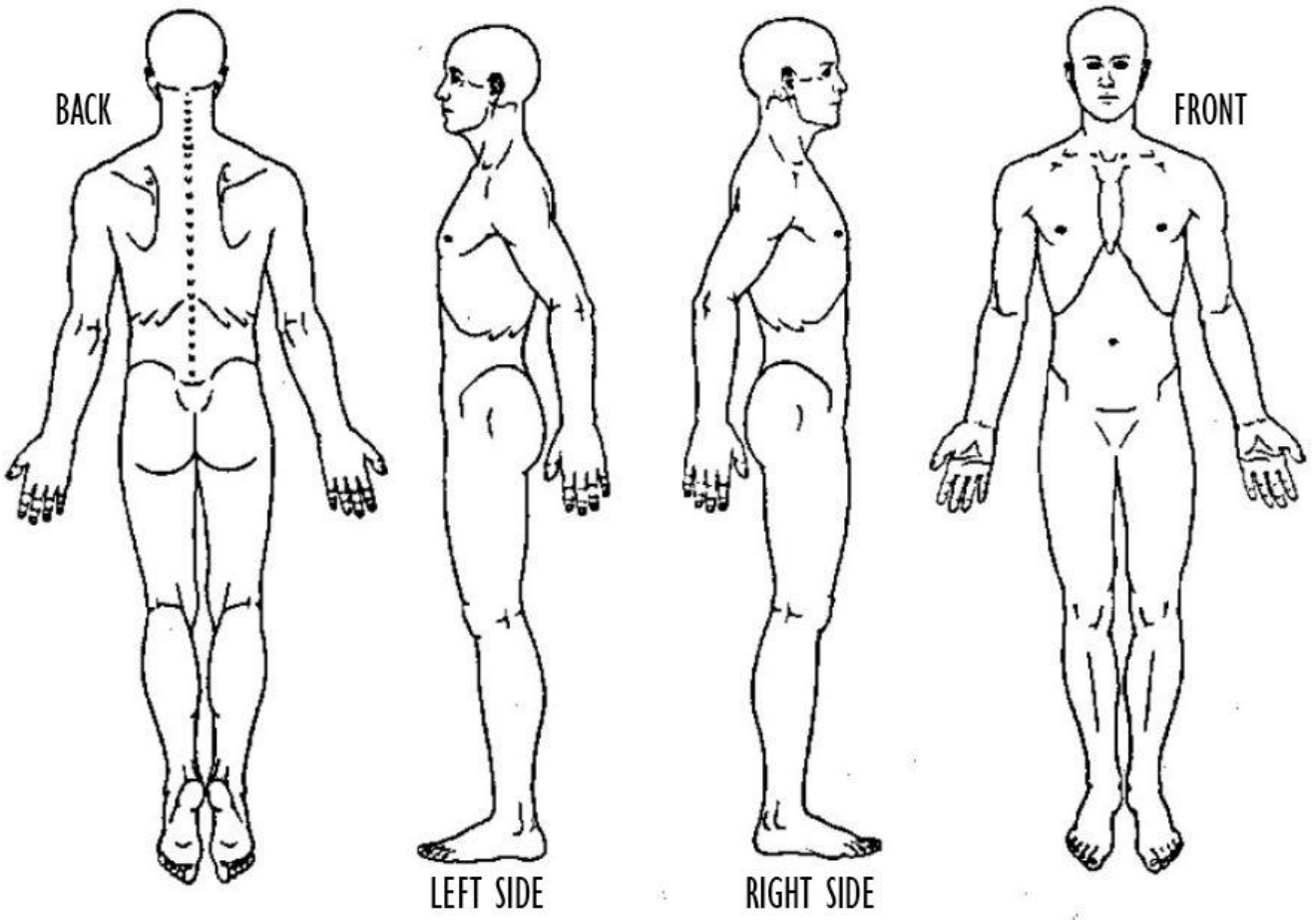
SAFETY

Client Transfer / Dependency Level 1, 2, 2+, 3

Transfers	Independent Unsupervised	Independent Supervised	Minimum Assistance	One-Person Pivot	Two-Person Side-by-Side	Lifting Devices Two-Person	Reposition One Person or Two
Initial							

BODY CHART

Document assessment findings directly on the body and note the narrative in client file.



FALLS RISK ASSESSMENT TOOL

Client Name: _____

Date Completed: _____ Staff Signature: _____

If client has any of the following conditions, check the box and apply Fall Risk interventions as indicated.

High Fall Risk - Implement High Fall Risk interventions per protocol

- ☐ History of more than one fall within 6 months before referral to **Nnenia Extended Care Services, Inc**
- ☐ Client is deemed high fall-risk per protocol (e.g., seizure precautions)

Low Fall Risk - Implement Low Fall Risk interventions per protocol

- ☐ Complete paralysis or completely immobilized
- ☐ Do not continue with Fall Risk Score Calculation if any of the above conditions are checked.

FALL RISK SCORE CALCULATION – Select the appropriate option in each category. Add all points to calculate Fall Risk Score. (If no option is selected, score for category is 0)	Points
Fall History (single-select) ☐ One fall within 6 months before referral to Nnenia **(5 points)**	
Elimination: Bowel and/or Urine (single-select) ☐ Incontinence **(2 points)** ☐ Urgency or frequency **(2 points)** ☐ Urgency/frequency and incontinence **(4 points)**	
Medications: Includes anticonvulsants, anti-hypertensives, diuretics, laxatives, and Psychotropics (single-select) ☐ On 1 high fall risk drug **(3 points)** ☐ On 2 or more high fall risk drugs **(5 points)**	
Mobility (multi-select; choose all that apply and add points together) ☐ Requires assistance | supervision for mobility, transfer, or ambulation **(2 points)** ☐ Unsteady gait **(2 points)** ☐ Visual or auditory impairment affecting mobility **(2 points)**	
Cognition (multi-select; choose all that apply and add points together) ☐ Altered awareness of immediate physical environment **(1 point)** ☐ Impulsive **(2 points)** ☐ Lack of understanding of one's physical and cognitive limitations **(4 points)**	
Total Fall Risk Score (Sum of all points per category) **Refer to Falls Protocol for Interventions based on total Fall Risk Score**	

CONSENT TO PARTICIPATE

I, _____ give permission for _____ (client name) to participate in **Nnenia Extended Care Services, Inc.** programs, vocational, and recreational activities, including community outings in company vehicles.

Waiver of Liability

I, hereby, release Nnenia Extended Care Services Inc from any damages or injuries resulting from the programs, vocational and recreational activities, including community outings in company vehicles.

Client / Parent / Guardian	Signature	Date
Witness / Relationship to Client	Signature	Date

CONSENT FOR MEDICAL TREATMENT

Client Name: _____

Date of Expected Treatment: _____

I authorize Dr. _____ or whomever he/she may designate to perform on _____ (name of client / myself) the following procedure and/or treatment: _____

_____

I understand that this Consent to Treatment form and the treatment provided as described above will be governed by the laws of the Province of Ontario and I consent not to entertain any action, suit or proceeding in respect of, or in any way relating to, such treatment against Nnenia Extended Care Services, Inc.

By initialing here: _____ , I certify that I have read and fully understand the above Consent to treatment and that the explanations referred to were in fact made to me and that the form was filled in prior to treatment. I also certify that I was given an opportunity to ask questions and all of my questions have been satisfactorily answered. By signing below, I acknowledge my understanding of the information above and that I agree to proceed with treatment as proposed.

_____ _____

Signature of Client / Parent / Guardian / Authorized Person Date

Relationship of Person Signing on Behalf of Client: _____

Note: When a client is a minor and incapable of consenting to the treatment or the law requires parental/guardian consent, the consent of a parent, guardian or substitute decision maker must be obtained.

Witness: In my opinion, the Client/parent/guardian appears able to understand the treatment proposed and information provided concerning the treatment.

_____ _____

Signature of Witness Date

CONTACT:

Nnenia Extended Care Services Inc
Executive Director: Nyree Walton
nneniaextendedcare@gmail.com
Mobile: (647) 915-5766

This has been prepared exclusively for NNENIA EXTENDED CARE SERVICES, Inc.
by:

Intake and Admission Package Date: April 30, 2022