SOLICITUDE SUPPORT SERVICES

CLIENT PERSONAL FACESHEET AND PROFILE

SECTION ONE: IDENTIFYING INFORMATION

Individual's Name:		
D.O.B.		
Intake Date:	Discharge Date:	
Address:		
Telephone:	Fax:	
Supervisor:	House: ❒ Nathan ❒ Patterson	
Health Card:	Vers. Code:	Exp:
Sending Agency:	**Case Manager:**	
Family / Guardian Contacts		
Name:	Relationship to Individual:	
Address:		
Telephone:		
Email:		
Name:	Relationship to Individual:	
Address:		
Telephone:		
Email:		
Emergency Contact (in case Family Contact not available):		
Name:		
Relationship:		
Address:		
Email:	Telephone:	

Other Guardian (circle one): **Crown Ward** **Substitute Decision Maker** **Trustee (OPGT)**

If one of above, name: _____ Contact #: _____

Are you planning to relinquish, or are you in the process of relinquishing, parental rights? Yes ☐ No ☐

Reason for Referral to Solicitude Support Services:

Diagnosis(es) / Brief Summary of Needs:

Is the Individual Self-Signing (circle one): Yes No Exceptions: _____

Involved in Day Program? Specify: _____ Continuing? _____

Gender:	**School / Education:**	**Grade / Level Achieved:**
Religion:	**Cultural Identity:**	
Restricted Contacts:		

*If applicable: First Nation, Inuit, and Métis Identity Characteristics (when applicable, indicate specific band council representative / individual contact, with relevant contact information.)

CLIENT PERSONAL FACESHEET AND PROFILE

Services Required:		Length of Stay:	
❒	Daily	❒	1-3 Months
❒	Weekends	❒	4-8 Months
❒	Monthly	❒	9-12 Months
❒	Day Program	❒	Yearly

Describe Current Difficulties / Challenges / Concerns:

SECTION TWO: COMMUNICATION / DENTAL / VISION / HEARING

Is the Individual Verbal or Non-Verbal (circle one): Verbal Non-Verbal Some

Languages Spoken / Understood (check all that apply in table below):

	English	French	Spanish	Italian	Mandarin	Punjabi		
Spoken / Conveyed								
Understood								
Written								
Read								

Verbal Expressions:

Easily Understood: Yes ☐ No ☐ Difficulty expressing him/herself: Yes ☐ No ☐

Slurred / Mumbled Speech: Yes ☐ No ☐ Understands Directions: Yes ☐ No ☐

Dental / Vision / Hearing:

Dental Prosthetics (Indicate): _____

Vision: Glasses? Yes ☐ No ☐ Glaucoma? Left ☐ Right ☐

Legally Blind? Left ☐ Right ☐ Contact Lenses? Yes ☐ No ☐

Hearing:

Does Individual have a Hearing Impairment? Yes ☐ No ☐ Hearing Aid? Left ☐ Right ☐

SECTION THREE: LEVEL OF SUPPORT REQUIRED

Tier-Level Support Required (circle one): Tier One Tier Two Tier Three

*Note: **All three (3) tiers of support require 24/7 support (always staffed)**, but each determines level of support required to accomplish day-to-day tasks, activities of daily living, community outing support, etc.*
Tier One: Some independence, dresses self, can do tasks with prompts, can toilet independently, etc.
Tier Two: Minimal independence, requires consistent prompts, some hand over hand, hygiene support, etc.
Tier Three: Full support (feeding, hygiene, dressing, etc.). Could be non-verbal, prone to seizures, needs sleep support (i.e., constant eyes-on)

SECTION FOUR: MEDICAL AND HEALTH SUMMARY

Diagnosis(es):

Psychiatrist's Name: _____ Contact #: _____

Address: _____ Date of Last Medication Review: _____

If different from above:

Prescribing Physician's Name: _____ Contact #: _____

Address: _____ Date of Last Medication Review: _____

Most Recent Medical Appointments Attended and Dates:

Physician: _____ Date: _____ Follow-up: _____

Psychiatrist: _____ Date: _____ Follow-up: _____

Dentist: _____ Date: _____ Follow-up: _____

Optometrist: _____ Date: _____ Follow-up: _____

Audiologist: _____ Date: _____ Follow-up: _____

Specialist : _____ Date: _____ Follow-up: _____

Specialist : _____ Date: _____ Follow-up: _____

Specialist : _____ Date: _____ Follow-up: _____

Current Medication(s) including PRNs (Dosage, Times, Route, Special Instructions, such as apple sauce):

Over-the-Counter Medications / Supplements / Vitamins / Minerals:

Medication Summary / Increases / Decreases / Trials Since Admission:

Allergies – List All (Food / Medication / Environmental). Epi-Pen?

Summary of Overall Health Status:

Medical / Ambulatory Equipment / Personal Assistance Service Devices Used:

Seizure Information

Does the Individual have Seizures?: Yes ☐ No ☐

Details of Seizures (Times, Random, Frequency, Any Details Available)

SECTION FIVE: CONTINENCE STATUS / MANAGEMENT

Is the individual continent of urinary function? Yes ☐ No ☐

Is the individual continent of bowel function? Yes ☐ No ☐

If the answers to the above questions are "no", please complete the following section as appropriate:

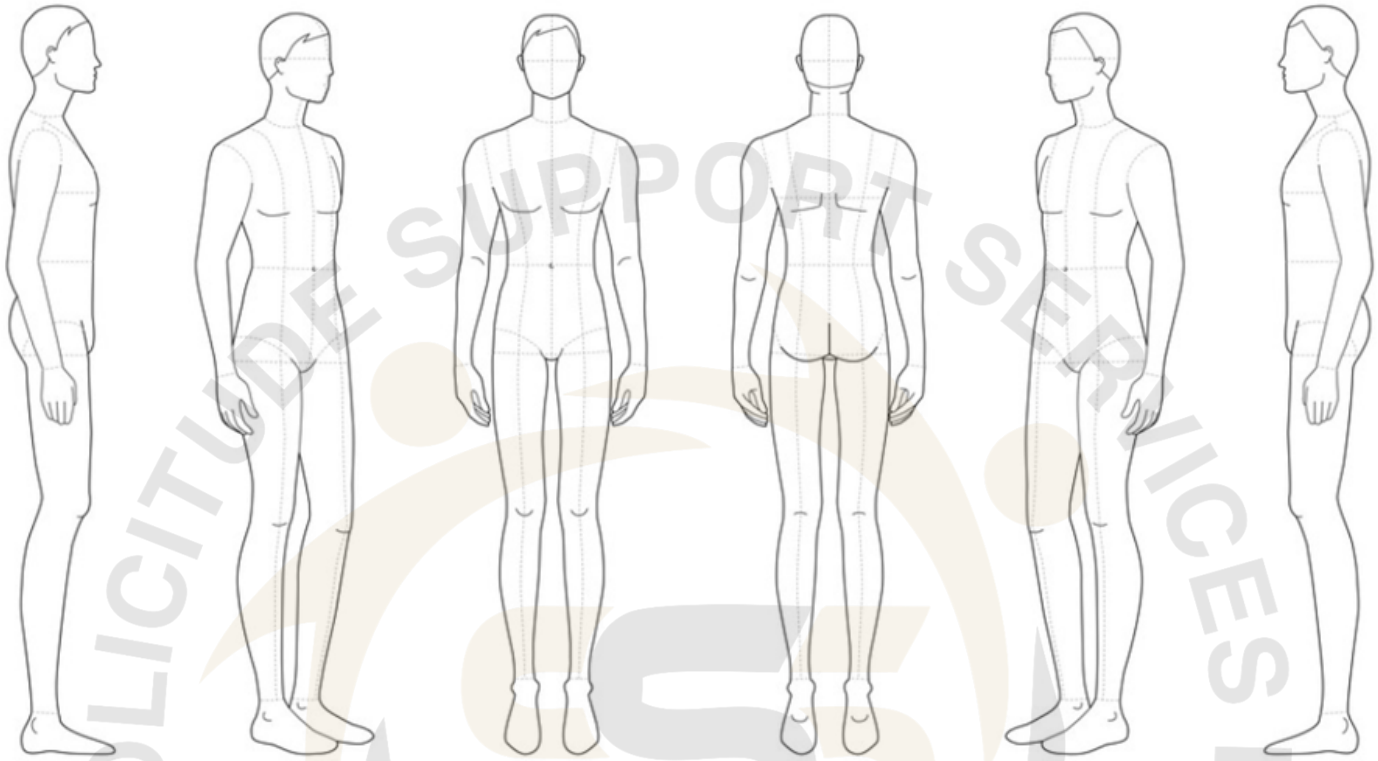
Urinary Incontinence		Bowel Incontinence	
❍ Several times a week	❍ Day Only	❍ Several times a week	❍ Day Only
❍ Daily	❍ Night Only	❍ Daily	❍ Night Only
	❍ Day and Night		❍ Day and Night

Current Management Techniques	Current Management Techniques
❍ Prompting / reminding / defers incontinence	❍ Uses incontinence pads / adult diapers:
❍ Timed voiding defers incontinence	❍ Day only
❍ Uses incontinence pads / adult diapers:	❍ Night only
❍ Day only	❍ Day and night
❍ Night only	Comments: _____
❍ Day and night	_____
Catheter (specify type): _____	_____
Comments: _____	
_____	
Can individual self-manage incontinence?: Yes ☐ No ☐	Can individual self-manage incontinence?: Yes ☐ No ☐

Any Additional Pertinent Medical Information:

CLIENT PERSONAL FACESHEET AND PROFILE

SECTION SIX: BODY CHART



LEGEND OF *INDICATORS* TO BE USED ON BODY CHART:

AB	Abscess (swollen area with pus/fluid)	**BU**	Burn (describe origin)	**GR**	Grab Marks (or pinch)
BI	Bite mark (describe in notes if skin broken)	**CU**	Cut (skin broken)	**SC**	Scrape (scratch, abrasion)
BR	Bruise (describe shape, size, colour, etc.)	**FR**	Fractured Bone (break)	**O**	Other:

CORRESPONDING NOTES / FINDINGS ASSOCIATED WITH INDICATORS :

Note ANY / ALL descriptions about indicators on Body Chart. Be specific.
Complete a separate entry into chart below for each mark or injury.

Indicator? (as per Indicator Legend)	Description? (type of injury / mark)	Location on Body? (as indicated on Body Chart)	When did mark or injury occur? (if known)	Details (full accurate details of mark or injury: bleeding, colour, size, how did it occur, who was involved, time of day, where it occurred, etc. Be specific.)

SECTION SEVEN: ASPECTS OF DAILY LIVING / PROTOCOLS

Individual's Customary Daily Routine Summary

Sleeping Routine: Preferred Wake-Up Time: _____ Napping Routine: _____

Preferred Bedtime: _____ Night Sleep Pattern: _____

Comments: _____

Bathing Routine: Prefers Baths ❒ Showers ❒ Frequency: _____

Comments: _____

Brief Summary of Hygiene Protocol:

Eating Routine: Food Preferences (religious, cultural, etc.) : _____

Food Dislikes: _____

Comments: _____

Daily Events (Check all that apply)

- ❒ Goes out ___ days per week (specify 1-7)
- ❒ Spends most time alone
- ❒ Spends most time watching television
- ❒ Prefers small group activities
- ❒ Stays busy with hobbies, reading, fixed routine
- ❒ Contact with family/friends ___ days per week (specify 1-7)
- ❒ Usually attends church, synagogue, mosque, etc.
- ❒ Prefers large group activities

Comments: _____

SUMMARY OF THE INDIVIDUAL'S OVERALL ABILITIES AND CHALLENGES

SHORT-TERM / LONG-TERM GOALS IN PROGRESS / STATUS / TIMELINES

SECTION EIGHT: BEHAVIOURAL ASSESSMENT

Hospitalization:

Has individual ever been hospitalized? (Specify) _____

_____

Has individual ever been admitted on a Form 1? (Specify) _____

_____

Checklist: Please check any of the following in each area that describes client

Environmental Triggers

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

Response to sounds, speech:

- ☐ Often ignores sounds
- ☐ Often ignores what is said to him/her
- ☐ Afraid of certain sounds
- ☐ Really likes certain sounds (music, sound therapy)
- ☐ Seems to hear distant or soft sounds that others don't hear or notice
- ☐ Unpredictable response to sounds (sometimes reacts / sometimes doesn't)

Visual Response

- ☐ Stares vacantly around room
- ☐ Distracted by lights /Stares at lights
- ☐ Often doesn't look at things
- ☐ Very interested in small parts of an object
- ☐ Likes to look at self in mirror
- ☐ Looks at things out of corner of eyes

Emotional Response

- ☐ Temper tantrums (mood swings)
- ☐ Laughs/smiles for no obvious reason
- ☐ Overly responds to situations
- ☐ Often has blank expression on face
- ☐ Cries/seems sad for no reason
- ☐ Little response to stimuli in environment

Relating to Others

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

Describe how the individual interacts with:

Parents: _____

_____

Siblings / Family: _____

_____

Peers: _____

_____

Staff / Others in Community: _____

_____

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

Timid	Friendly	Happy	High-Strung	Moody	Agitated
Quiet	Anxious	Sensitive	Aggressive	Nervous	Easy-Going

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	☐ Over-activity
☐ Hitting	☐ Pulls out own hair	☐ Depressed	☐ Inattentive
☐ Argumentative	☐ Damage to property	☐ Bed-wetting	☐ Running away
☐ Throwing objects	☐ Profanity/verbal threats	☐ Smearing feces	☐ Suicidal

Self-Injury (specify): _____

Other (specify): _____

What are the concerns and what are the causes for above behaviours: _____

_____

Describe these behaviours: _____

_____

Best way to approach individual: _____

_____

Strategies for behaviour management (de-escalation strategies): _____

_____

_____

SECTION NINE: SAFETY PLAN

Safety:

Client Transfer Required?	**Yes**	☐	**No**	☐
Is Client a Fall Risk?	**Yes**	☐	**No**	☐

IS THERE A SAFETY PLAN IN PLACE? IF SO, DESCRIBE AND ATTACH COPY

INDIVIDUAL'S LIKES / HOBBIES / INTERESTS

INDIVIDUAL'S DISLIKES / PROVEN (OR POTENTIAL) TRIGGERS

BEST WAY TO APPROACH IF INDIVIDUAL IS ESCALATED OR TRIGGERED
(What works and what doesn't)

SECTION TEN: OTHER MEMBERS OF INDIVIDUAL'S SUPPORT TEAM:

Behavioural Therapist Name: _____ Contact #: _____

Occupational Therapist Name: _____ Contact #: _____

Speech Pathologist Name: _____ Contact #: _____

Psychologist Name: _____ Contact #: _____

Social Worker Name: _____ Contact #: _____

Music Therapist Name: _____ Contact #: _____

Art Therapist Name: _____ Contact #: _____

Resource Person Name: _____ Contact #: _____

Team Member Name: _____ Contact #: _____

Team Member Name: _____ Contact #: _____

SECTION ELEVEN: SUPPORTING DOCUMENTATION/ASSESSMENTS, ETC.:

- ❍ School Report(s)
- ❍ Immunization Record
- ❍ Annual Physical
- ❍ DSO Assessment Report
- ❍ Other: _____
- ❍ Police Report(s)
- ❍ Medication Summary
- ❍ Serious Occurrence Reports
- ❍ Psychological Assessment(s)
- ❍ Other: _____

Does the Individual have a valid Canadian Passport (circle one): **Yes** **No**

ASSESSMENTS:

PSYCHIATRIC REPORTS

Psychiatrist	Date of Assessment	Telephone #	Reports Attached?

PSYCHOLOGICAL REPORTS

Psychologist	Date of Assessment	Telephone #	Reports Attached?

DSO / ASSESSOR ASSESSMENT SUMMARY REPORT

DSO / Assessor Report	Date of Assessment	Telephone #	Reports Attached?

SOCIAL WORK/PSYCHOSOCIAL REPORTS

Social Worker/Therapist	Date of Assessment	Telephone #	Reports Attached?

BEHAVIOURAL CONSULTANT REPORTS

Behavioural Consultant	Date of Assessment	Telephone #	Reports Attached?

OCCUPATIONAL THERAPY / SPEECH THERAPY REPORTS

OT/Speech Consultant	Date of Assessment	Telephone #	Reports Attached?

SECTION TWELVE: PREVIOUS RESIDENCE AND HISTORICAL DATA

Previous Residence(s):

Has individual ever resided in a Residential Placement? **Yes** ☐ **No** ☐

Specify: _____

Has individual ever been discharged or evicted from a residence? **Yes** ☐ **No** ☐

Explain in detail: _____

_____

_____

Has individual ever attempted suicide or threatened suicide? **Yes** ☐ **No** ☐

Explain in detail: _____

_____

Has individual ever been involved with police or been arrested? **Yes** ☐ **No** ☐

Explain in detail: _____

_____

Has individual been involved with the court system/incarcerated? **Yes** ☐ **No** ☐

Explain in detail: _____

_____

Does individual have a history of medication refusal? **Yes** ☐ **No** ☐

Explain in detail: _____

_____

Has individual ever been considered a “flight risk”? **Yes** ☐ **No** ☐

Explain in detail: _____

_____

Has individual ever damaged property (structural or items)? **Yes** ☐ **No** ☐

Explain in detail: _____

_____

CLIENT PERSONAL FACESHEET AND PROFILE

Does individual require special accommodations in residence? **Yes** ☐ **No** ☐

Explain (i.e., mattress off frame / windows latches removed): _____

_____

Does individual have a history of falsely accusing any staff of any abusive behaviour toward them? **Yes** ☐ **No** ☐

Explain in detail: _____

Does individual require monitoring while using the internet? **Yes** ☐ **No** ☐

Explain in detail: _____

Does individual have a propensity for sexually inappropriate behaviour (towards self or others)? **Yes** ☐ **No** ☐

Explain in detail: _____

Please describe individual's staffing support requirements (i.e., 1:1, 2:1, etc.), and the number of hours this staffing support is required.

Staffing Needs: _____ Number of Hours: _____

Explain what type of staffing was required in previous home, what level of support in previous home, and what protocols existed to meet the needs of the individual:

SECTION THIRTEEN: PHYSICAL FUNCTION

TASK	LEVEL OF ASSISTANCE	COMMENTS
Eating: Ability to feed self meals and snacks	❍ **Independent:** Able to feed self independently with or without assistive device. ❍ **Intermittent Assistance:** Requires minimal, intermittent supervision and/or assistance. ❍ **Continual Assistance:** Requires constant assistance and/or supervision throughout meal. ❍ **Total Assistance:** Unable to feed self, needs to be fed by staff.	**Eating Information (check all that apply):** ❍ Dentures ❍ Chewing difficulties ❍ Difficulty swallowing ❍ Modified food consistency needed **Specify:** _____ ❍ Other (specify):
Ambulation: Ability to walk and move about once in a standing position	❍ **Independent:** Walks and climbs and descends stairs independently with or without assistive device. ❍ **Intermittent Assistance:** Walks and climbs and descends stairs with minimal intermittent supervision and/or assistance. ❍ **Continual Assistance:** Walks and climbs and descends stairs with constant assistance and/or supervision. ❍ **Total Assistance:** Unable to leave ones' chair or bed. Requires total assistance for mobility.	**List all ambulatory equipment:** ❍ Wheelchair ❍ Walker ❍ Quad Cane ❍ Other (specify): Any falls within last three (3) months? **Yes** ☐ **No** ☐ **Number:** _____ **Frequency:** _____ **Injuries:** _____
Transferring: Moving from bed to chair, on/off toilet, in/out of shower or tub	❍ **Independent:** Able to transfer independently with or without assistive device. ❍ **Intermittent Assistance:** Transfers with minimal human supervision and/or assistance. ❍ **Continual Assistance:** Unable to transfer but can bear weight and pivot when transferred by at least one other person. ❍ **Total Assistance:** Unable to leave ones' chair or bed, unable to transfer, pivot, bear weight or turn self in bed without full assistance.	Comments:
Toileting: Getting to/from and on/off toilet, cleansing self after elimination and adjusting clothing	❍ **Independent:** Able to toilet independently with or without assistive device. ❍ **Intermittent Assistance:** Able to toilet with minimal intermittent supervision and/or assistance. ❍ **Continual Assistance:** Able to toilet with constant assistance and/or supervision. ❍ **Total Assistance:** Unable to toilet, total assistance with toileting required.	Comments (including the use of incontinence products, wipes, or cream):

SECTION THIRTEEN: PHYSICAL FUNCTION, continued

TASK	LEVEL OF ASSISTANCE	COMMENTS
Bathing: Getting in and out of shower or tub, washing and drying entire body	❍ **Independent:** Able to bathe or shower independently with or without assistive device. ❍ **Intermittent Assistance:** Able to bathe or shower with minimal intermittent supervision and/or assistance. ❍ **Continual Assistance:** Able to bathe or shower with constant assistance and/or supervision. ❍ **Total Assistance:** Unable to bathe or shower, needs to be bathed in bed or at bedside.	Comments (including preference of male or female staff):
Dressing: Getting clothes from closets, drawers, dressing and undressing upper/lower body, incl. buttons, snaps, zippers, socks and shoes	❍ **Independent:** Able to dress and undress independently with or without assistive device. ❍ **Intermittent Assistance:** Able to dress and undress with minimal intermittent supervision and/or assistance. ❍ **Continual Assistance:** Requires assistance throughout the dressing and undressing process. ❍ **Total Assistance:** Requires another person to dress and undress upper and lower body.	Comments:
Grooming: Washing face, hair care, shaving, teeth/denture, fingernail care, eyeglasses care	❍ **Independent:** Able to groom self independently with or without assistive device. ❍ **Intermittent Assistance:** Requires grooming utensils to be set up and placed within reach ❍ **Continual Assistance:** Requires assistance throughout the grooming process. ❍ **Total Assistance:** Depends entirely upon someone else for grooming.	Comments (be specific):
Laundry: Able to do own laundry – to carry to / from machine, to use washer / dryer	❍ **Independent:** Able to take care of all laundry tasks independently. ❍ **Intermittent Assistance:** Able to do basic loads with minimal assistance, or extra assistance with heavy / larger loads (bedding/towels). ❍ **Continual Assistance:** Requires constant assistance and/or supervision throughout laundry process. ❍ **Total Assistance:** Unable to do any laundry.	Comments:

SECTION THIRTEEN: PHYSICAL FUNCTION, continued

TASK	LEVEL OF ASSISTANCE	COMMENTS
Housekeeping: Ability to safely and effectively perform light housekeeping and somewhat heavier cleaning tasks	❍ **Independent:** Able to independently perform all required housekeeping tasks (make bed, clean room, do dishes, vacuum, etc.) ❍ **Intermittent Assistance:** Able to do minimal tasks by self (wipe counters, make bed), but requires intermittent supervision and/or assistance with more significant tasks (dishes). ❍ **Continual Assistance:** Unable to consistently perform tasks without assistance and/or supervision from another person. ❍ **Total Assistance:** Unable to effectively participate in any housekeeping tasks.	Comments (be specific):
Transportation: Ability to travel in various forms or transportation (cars, buses, trains, planes)	❍ **Independent:** Able to get in/out of vehicle and buckle in /and sit well during transport. ❍ **Intermittent Assistance:** Requires minimal intermittent supervision and/or assistance to get in/out of vehicle and to remain seated and buckled in during trips (verbal prompts). ❍ **Continual Assistance:** Requires more frequent assistance and/or supervision throughout transport with a person sitting next to them. ❍ **Total Assistance:** Requires constant assistance to get in/out of vehicles, with constant supervision and assistance to remain buckled in and safe from attempting to unbuckle and move about vehicle.	Comments (include any assistive devices required for travel):
Shopping: Ability to assist with grocery shopping and selecting required items and helping at checkout.	❍ **Independent:** Able to help out getting groceries, including remaining with person shopping while in stores, and assisting with carrying groceries from car to home. Stays close in parking lots. ❍ **Intermittent Assistance:** Requires minimal intermittent prompts to remain with person shopping in store and to retrieve required items and help with checkout. Prompts in parking lot. ❍ **Continual Assistance:** Requires constant assistance and/or supervision throughout the store, and only able to assist person shopping with full assistance and support in parking lot. ❍ **Total Assistance:** Unable to help with shopping. Must have someone do all shopping without helping in shopping process.	Comments:

CLIENT PERSONAL FACESHEET AND PROFILE

SECTION FOURTEEN: FUNDING SOURCE(S) INFORMATION:

- ❍ Ontario Disability Support Plan (ODSP)
- ❍ Ministry (MCCSS) Funding
  Interim or Permanent *(Circle One)*
- ❍ Indigenous Services Funding
- ❍ Other: _____
- ❍ Ontario Works (OW)
- ❍ Passport One Funding
- ❍ Emergency Placement Funding
  Ministry or Sending Agency *(Circle One)*
- ❍ Other: _____

SECTION FIFTEEN: COMPREHENSIVE SENDING ORGANIZATION / PICK-UP INFORMATION:

Organization Name: _____ Sending Contact Name: _____

Organization Address: _____ Contact #: _____

Date of Pick-up from Residence/hospital, etc: _____ Transport Method: _____

Is Medication Transfer Form Completed and Attached? Yes ☐ No ☐

ADDITIONAL COMMENTS

SECTION SIXTEEN: ACKNOWLEDGEMENT AND CONFIRMATION OF ACCURACY

I understand that a referral is being made for my son/daughter/family member/client to Solicitude Support Services. By signing this document, I am giving my permission to release ALL historical and supporting documentation and information regarding my son/daughter/family member/client and that ALL historical and supporting documentation and information will be included and attached with this document in order to proceed to the next level of review and potential acceptance.

I declare that all information in this document is exhaustive, comprehensive and truthful to the best of my knowledge. If ANY information is intentionally withheld that is required for the determination of "good fit" and subsequent placement and revealed at a later date as a result of crisis, or results in crisis, immediate discharge from Solicitude Support Services within 24 hours will occur. I understand that in order for Solicitude Support Services to place an individual within their care, it is imperative that they receive a comprehensive account of all details regarding my son/daughter/family member/client with respect to needs, behaviours, history, etc. **prior** to a placement agreement in order to best determine if a "good fit" is possible. I further understand that this is done in the best interest of not only my son/daughter/family member/client, but also in the best interest of other residents that would be cohabitating with my son/daughter/family member/client.

In the event that a client is going to be leaving Solicitude Support Services, prior to or after thirty-one (31) days, the sending agency/parent/guardian/ family member/trustee must provide thirty (30) days' advance notice of client vacating Solicitude Support Services. If such notice is not provided to Solicitude Support Services, the sending agency/parent/guardian/family member/trustee will be responsible for the per diem rate of thirty (30) days, and the cost of support hours for the full thirty (30) days.

As the sending agency/parent/guardian/ family member/trustee signing this agreement, I acknowledge all statements made and am in agreement with this Intake and Admission form for potential placement, and sign below to this effect.

SIGN-OFF SHEET

Supported Individual: _____ Signature: _____ Date: _____

Parent / Guardian: _____ Signature: _____ Date: _____

Parent / Guardian: _____ Signature: _____ Date: _____

Relationship to Supported Individual: _____

Case Manager: _____ Signature: _____ Date: _____

Solicitude Support Services Director: _____ Signature: _____ Date: _____

Supervisor: _____ Signature: _____ Date: _____

ACCCM/Team Lead: _____ Signature _____ Date _____

Trustee: _____ Signature _____ Date _____

Behavioural Therapist: _____ Signature: _____ Date: _____

Receiving Party: _____ Signature: _____ Date: _____

Additional Attendee: _____ Signature: _____ Date: _____

Additional Attendee: _____ Signature: _____ Date: _____

SOLICITUDE SUPPORT SERVICES

CLIENT PERSONAL FACESHEET AND PROFILE

OFFICE USE ONLY

- ☐ Accepted for Residential Placement
- ☐ Not Good Fit for Placement
- ☐ Placed on Waiting List for Placement
- ☐ Waiting on Assessment / Documentation
- ☐ All Assessment / Documentation Provided
- ☐ Nathan Cres. ☐ Patterson Rd.
- ☐ Accepted to Day Program
- ☐ Trial / Observation Period Length of Trial Period: _____

COVID Vaccination Received? ☐ YES ☐ NO

	SHOT REC'D		VACCINE NAME	VACCINE PROOF PROVIDED	DATE
If yes, please check all that apply, and dates received.	☐	Shot # 1			
	☐	Shot # 2			
	☐	Booster # 1			
	☐	Booster # 2			
	☐	Booster # 3			

If no vaccine received, has medical exemption documentation been provided? ☐ YES ☐ NO

Other (Documentation, Information, etc.)

Intake Coordinator Signature

Date

SOLICITUDE SUPPORT SERVICES

CLIENT PERSONAL FACESHEET AND PROFILE

ROMANA PHARMACY NEW CLIENT FORM

Supported Individual:	Date of Birth:	Health Card #:	
		Version Code:	
		Expiry Date:	
Diagnosis(es):	Previous Pharmacy Information:		
	Name:		
	Address:		
	Phone:	Fax #:	
MAR Sheet attached?	❒ YES	❒ NO	
Has valid Health Card been scanned?	❒ YES	❒ NO	
Frequently Dispensed Completed Below?	❒ YES	❒ NO	

1	Prescription/RX #:	Medication Name:	Dose:
			Time(s):
	Prescribed by:	Prescriber's Phone Number:	Route:
			Instructions (e.g. in apple sauce):

2	Prescription/RX #:	Medication Name:	Dose:
			Time(s):
	Prescribed by:	Prescriber's Phone Number:	Route:
			Instructions (e.g. in apple sauce):

3	Prescription/RX #:	Medication Name:	Dose:
			Time(s):
	Prescribed by:	Prescriber's Phone Number:	Route:
			Instructions (e.g. in apple sauce):

4	Prescription/RX #:	Medication Name:	Dose:
			Time(s):
	Prescribed by:	Prescriber's Phone Number:	Route:
			Instructions (e.g. in apple sauce):

5	Prescription/RX #:	Medication Name:	Dose:
			Time(s):
	Prescribed by:	Prescriber's Phone Number:	Route:
			Instructions (e.g. in apple sauce):

6	Prescription/RX #:	Medication Name:	Dose:
			Time(s):
	Prescribed by:	Prescriber's Phone Number:	Route:
			Instructions (e.g. in apple sauce):

7	Prescription/RX #:	Medication Name:	Dose:
			Time(s):
	Prescribed by:	Prescriber's Phone Number:	Route:
			Instructions (e.g. in apple sauce):

Cross off any unneeded medication tables above.
If additional tables are required, please complete an additional form and attach to first.

Supervisor Name _____ Signature _____ Date of Submission _____