

APPLICATION FOR OUTREACH SERVICES

First Name:		Last Name:			
Sex:		Date of Application:	<small>Day</small>	<small>Month</small>	<small>Year</small>
Current Address:					
City:		Province:		Postal Code:	
Telephone (Home):			Telephone (Work):		
Email address:					
Date of Birth:	<small>Day</small>	<small>Month</small>	<small>Year</small>	Health Card No.	

Type of Physical Disability:	

Describe how this condition affects the ability of the applicant to complete activities of daily living:	

Is this condition likely to:	<input type="checkbox"/> Improve <input type="checkbox"/> Remain stable <input type="checkbox"/> Gradually deteriorate <input type="checkbox"/> Rapidly deteriorate
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Name of Family doctor:		
Address:		Telephone #

Is the applicant currently receiving services from any other organizations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<i>Name of service provider:</i>	<i>Type and amount of service:</i>

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Attendant services:	
What services is the applicant requesting from Nucleus? Check all that apply	
<input type="checkbox"/> Personal care (includes bathing, dressing, personal hygiene, bowel/bladder routines) <input type="checkbox"/> Assistance with transfers <input type="checkbox"/> Meal Preparation and/or assistance with eating <input type="checkbox"/> Assistance with adaptive equipment or communication devices <input type="checkbox"/> Light housekeeping (only available if applicant is also in need of and is receiving personal care by Nucleus) <input type="checkbox"/> Other:	
Days of the week that service is required:	Time:
<input type="checkbox"/> Monday	
<input type="checkbox"/> Tuesday	
<input type="checkbox"/> Wednesday	
<input type="checkbox"/> Thursday	
<input type="checkbox"/> Friday	
<input type="checkbox"/> Saturday	
<input type="checkbox"/> Sunday	
Where will services be delivered? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> School	
Any other disabilities or medical conditions that may affect delivery of attendant services (i.e. visual/hearing impairments, epilepsy, diabetes, cognitive difficulties)	

Current Medications:

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Alternate Contact Information: *(person who can be contacted in an emergency if we are unable to reach applicant)*

Name:		Address:	
Telephone:			
Relationship:			

Referral Details: *(provide information if someone other than the applicant is completing the application)*

Name of Referrer:		Organization:	
Contact Telephone Number:			