MEALS ON WHEELS PROGRAM

CLIENT INTAKE FORM (Fill and return to admin@vschs.ca or call 250-566-4867)

Assessment ____ 1 - New 2 - Update

Referral Date _____

Referral Reason _____

Referred by _____ 1=Self 2=Relative 3=Doctor 4=PHN 5=Hospital 6=Home Care 7=Other

CLIENT DATA:

Last Name **First Name** **Initial**

_____ _____ _____

Home Phone _____ **Cell Phone** _____

Birthdate _____ (DD/MM/YYYY)

Residential Address _____

Features near home (optional) _____

Diet _____

Food Allergies _____

Name and Address or Email for Billing: _____

_____

Next of Kin

Name Relationship

_____

Address Telephone

_____

Contact Person Telephone

_____

Family Doctor Telephone

_____

Notes _____

_____

_____

Accommodation ____ A=Apartment B=House C=Seniors Apartment D=Other

Living _____ A = Alone B=Spouse C=Relative D= Other **Pets** _____ Y or N

_____