George's House Palliative Care Program

Application Form

APPLICANTS DEMOGRAPHICS

Client Name:			Circle: He / She / They	
Contact Number:				
Date of Birth:				
Personal Health Number:				
Diagnosis:				
Life Limiting Illness (prognosis approx. <6months):			Yes	No
Applicant would benefit from non-institutional care setting?			Yes	No
Goals of Care	M1	M2	C1	C2

REFERRING SUPPORT WORKER (IF APPLICABLE)

Name:
Agency or Program:
Contact Number:
Contact Email:

APPLICANTS HISTORY

Describe the applicant's current Living Situation: ______________________________

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____

Does the applicant have history of / or current diagnosis of substance use disorder? ______________

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____

Does the applicant have mobility limitations? ______________________________

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____

Has the applicant's behaviours been a source of significant risk of harm to themselves or others over the last year? If yes, please describe: ____ ____ ____

NAME OF PRIMARY CARE PROVIDER/PHYSICIAN (IF APPLICABLE)

Name:
Title:
Hospital/Clinic/Agency:
Contact Number:
Contact Email:
Additional medical supports applicant is accessing: ____ ____ ____

By signing below, I agree to apply to this program and give my permission for the program staff to contact persons listed in this application to discuss its contents in detail. I confirm that the information provided is accurate and up to date to the best of my ability.

Applicant Name:
Applicant Signature:
Date:

By signing below, I confirm that I assisted the applicant in completing the application form. I believe the information provided is accurate to the best of my knowledge.

Referring Worker Name:
Referring Worker Signature:
Date: