Skills for Transition March Break 2019

Section A – General Client Information

Last Name:	Initial:	First Name:	
Gender:	**Date of Birth *(dd/mm/yy):***	**Health Card Number:**	**Version Code:**

Parent/Guardian Telephone: Please provide a number where we can reach your parent/guardian

Name:

Telephone: ( ) ☐Home ☐Cell ☐Work
Telephone: ( ) ☐Home ☐Cell ☐Work
Telephone: ( ) ☐Home ☐Cell ☐Work

Name:

Telephone: ( ) ☐Home ☐Cell ☐Work
Telephone: ( ) ☐Home ☐Cell ☐Work
Telephone: ( ) ☐Home ☐Cell ☐Work

Other Emergency Contact:

Name:

Relationship:

Telephone: ( ) ☐Home ☐Cell ☐Work
Telephone: ( ) ☐Home ☐Cell ☐Work

Section B – Health Information

Please describe your disability:

Please describe if there is anything else we should be aware of (i.e. learning disability, vision impairment, etc):

Please describe how your answer(s) above affect you physically (i.e. transfers, communication, etc) or cognitively (i.e. processing information, etc) :

Do you experience seizures? ☐**Yes** ☐**No** **If yes, please list date of last seizure:** (dd/mm/yy)

Frequency:

Type of seizure:

Intervention/how they are managed:

Do you have any allergies? ☐Yes ☐No
Please specify - food, environmental, substance, etc.

Intervention/how they are managed:

Are there any special considerations staff should be aware of? **(i.e. do you have any practices specific to cultural beliefs; do you experience pain/discomfort; are there any foods you have difficulty eating; do you have anxiety in crowds, environments etc.?)**

Section C – Risk of falls

Is there a history of illness-related falls? ☐Yes ☐No	**If yes, please explain:**
Are there any strategies in place to prevent the occurrence of falls? ☐Yes ☐No	**If yes, please explain:**

Section D – Medication

Do you take any medication? ☐Yes ☐No **(Please consider routine medication, emergency medication and as needed medication such as Tylenol or Gravol)** **If yes, please list below**	**Do you take your medication on your own?** ☐Yes ☐No **If no, please indicate the type of assistance required:** ☐ Remembering when to take ☐ Remembering how much to take ☐ Storing medication ☐ Opening containers ☐ Administering medication ☐ Other:_____
Medication name: Reason for use: Dosage: Strength: Storage: Time given: Additional information:	Medication name: Reason for use: Dosage: Strength: Storage: Time given: Additional information:
Medication name: Reason for use: Dosage: Strength: Storage: Time given: Additional information:	Medication name: Reason for use: Dosage: Strength: Storage: Time given: Additional information:

**if not enough space, please attach additional sheets with additional information*

Section E – Assistive Devices

Do you use any mobility devices? ☐Yes ☐No	**If yes, please explain:**
Do you use any other assistive devices? ☐Yes ☐No	**If yes, please explain:**

Section F – Activities of Daily Living and Personal Care Requirements

Please indicate how much help you need for each of the activities below.

Task	Total Assistance	Some Assistance	No Assistance
Eating	☐	☐	☐
Please explain:			
Dressing (upper body)	☐	☐	☐
Please explain:			
Dressing (lower body)	☐	☐	☐
Please explain:			
Toileting	☐	☐	☐
Please explain:			
Transferring:	☐	☐	☐
Please explain:			

IF YOU NEED ASSISTANCE WITH TRANSFERING, please indicate your preferred method:
☐Hoyer ☐2-person transfer ☐1-person transfer

Please explain:

If you need assistance, are you able to describe what you need? ☐Yes ☐No

Please explain:

Section G – Activity Participation

Do you have any medical concerns that would make participation in physical activity risky? ☐Yes ☐No	**If yes, please explain:**
Do you need 1:1 assistance/ supervision in activities? ☐Yes ☐No	**If yes, please explain the type and frequency of support required:**

Section H: Verification and Signature

I verify that the information that has been given in this application is complete and accurate to the best of my knowledge.

Signature:	Date *(dd/mm/yy)*:

Please return this form to:
Holland Bloorview Kids Rehabilitation Hospital
Transitions, Recreation and Life Skills
Attn: Stephanie Di Martino
150 Kilgour Road
Toronto, ON M4G 1R8

Tel: 416.425.6220 ext. 3817 | Fax: 416.422.7037