

REQUEST FOR CLIENT INTERVENTION & ASSISTANCE SERVICES

Short-term social work services are available through CHAP to Chatham-Kent residents 60 years of age or older, adults with disabilities (18+), and residents of care homes or supported living. All services are client directed, confidential, and delivered at no cost. This is a voluntary program and service users can withdraw from the program at any time.

Personal Information		
Name:	City:	
Primary Address:	Postal Code:	
Primary #:	Alternate #:	
Email:	Can voicemail be left at these numbers? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Birth (M/D/Y):	Gender:	Pronouns:
Lives Alone? <input type="checkbox"/> Yes <input type="checkbox"/> No Lives with: _____		
Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Common Law <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Involuntary Separation (LTC)		
<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other: _____	<input type="checkbox"/> First Nations <input type="checkbox"/> Métis <input type="checkbox"/> Inuit <input type="checkbox"/> LGBTQI2S+: _____	
Is individual aware of & agreeable to referral? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Visual Impairment <input type="checkbox"/> Yes <input type="checkbox"/> No		Speech Impairment <input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Impairment <input type="checkbox"/> Yes <input type="checkbox"/> No		Mobility Aid(s) <input type="checkbox"/> Yes <input type="checkbox"/> No
Please specify: _____		
Reason(s) For Referral		
<input type="checkbox"/> Recent falls or mobility changes, falls risk <input type="checkbox"/> Recent physical or functional decline <input type="checkbox"/> Unsafe living environment <input type="checkbox"/> Cognitive decline (affecting hygiene, managing medication, banking, driving and/or meal preparation)	<input type="checkbox"/> Responsive behaviours (agitation, wandering, paranoia, hallucinations, inappropriate behaviour) <input type="checkbox"/> Caregiver(s) having difficulty coping / burnout <input type="checkbox"/> Other: _____	
Emergency Contact		
Name:	Relationship	
Primary #:	Alternate #:	Email:
Power of Attorney (only if applicable)		
POA Type (check all that apply): <input type="checkbox"/> Property <input type="checkbox"/> Personal Care		POA aware of & agreed to referral <input type="checkbox"/> Yes <input type="checkbox"/> No
Name:	Relationship:	
Address:		Postal Code:
Primary #:	Alternate #:	Email:
Identified Need (check all that apply)		
<input type="checkbox"/> Assistance with Forms <input type="checkbox"/> Community Referrals <input type="checkbox"/> Service Coordination <input type="checkbox"/> System Navigation <input type="checkbox"/> Advocacy <input type="checkbox"/> Safety & Wellbeing <input type="checkbox"/> Isolation <input type="checkbox"/> Self-Neglect <u>Elder Abuse*</u> : <input type="checkbox"/> Emotional <input type="checkbox"/> Physical <input type="checkbox"/> Financial <input type="checkbox"/> Sexual <input type="checkbox"/> Neglect * If Elder Abuse is suspected, a completed EASI screener must be submitted with this form.		

SERVICE INFORMATION

Are other community services currently providing support(s)? Yes No (if yes, please select below)

- Home & Community Care Support Services (LHIN) Family Service Kent Private in-home support services
 Canadian Mental Health Association (CMHA) Geriatric Mental Health Outreach Team (GMHOT)
 Veteran's Affairs Alzheimer Society New Beginnings Chatham-Kent Legal Clinic Chatham-Kent
 Other (please specify): _____

Does this individual have an existing case manager? Yes No (if yes, please specify below)

Is this individual currently on a wait list for services? Yes No (if yes, please specify below)

Is this individual currently on a wait list for Long-Term Care? Yes No (if yes, please specify below)

Are there potential safety risks for home or office visits? Yes No (if yes, please specify below)

Urgency of Referral

Please note that this is not a crisis service. If the individual is in immediate danger, please phone 9-1-1.

- Urgent (follow up within 1-2 business days)
 Important (follow up within a week)
 Non-urgent (routine assessment)

Additional Comments/Special Instructions**Referring Source**

- Healthcare Provider Specialist Family/Caregiver/SDM Self Hospital Agency/Other

Name of Referral Source: _____

Role: _____

Signature of Referral Source: _____

Date: _____

Submit completed forms via

Fax: 519-354-5152

Email: info@familyservicekent.com

Mail or In-Person: 50 Adelaide St. S Chatham, ON N7M 6K7

ELDER ABUSE SUSPICION INDEX © (EASI)

The EASI was developed* to raise a doctor's suspicion about elder abuse to a level at which it might be reasonable to propose a referral for further evaluation by social services, adult protective services, or equivalents. While all six questions should be asked, a response of "yes" on one or more of questions 2-6 may establish concern. The EASI was validated* for asking by family practitioners of cognitively intact seniors seen in ambulatory settings.

Q.1 - Q.5: ASK OF PATIENT.

Q1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	Yes	No	Did not answer
Q2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with?	Yes	No	Did not answer
Q3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	Yes	No	Did not answer
Q4. Has anyone tried to force you to sign papers or to use your money against your will?	Yes	No	Did not answer
Q5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	Yes	No	Did not answer

Q.6: ANSWERED BY DOCTOR.

Q6. Elder abuse <u>may</u> be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	Yes	No	Not sure
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*Yaffe MJ, Wolfson C, Lithwick M, Weiss D. Development and validation of a tool to improve physician identification of elder abuse: The Elder Abuse Suspicion Index (EASI) ©. Journal of Elder Abuse and Neglect 2008; 20(3) 276-300. Haworth Press Inc: <http://www.tandf.co.uk/journals/haworth-journals.asp>

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 Online copies of EASI: http://www.mcgill.ca/files/familymed/EASI_Web.pdf