## REQUEST FOR CLIENT INTERVENTION & ASSISTANCE SERVICES

Short-term social work services are available through Community Support Services (CSS) 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			hese numbers? □ Yes □ No			
Date of Birth (M/D/Y):	Gender:			Pronouns:			
Lives Alone? ☐ Yes ☐ No Lives with:							
Marital status: ☐ Married ☐ Common Law ☐ Separated ☐ Divorced ☐ Widowed ☐ Involuntary Separation (LTC)							
□ English □ French □ Other: □ First Nations □ Métis □ Inuit □ LGBTQI2S+:							
Is individual aware of & agreeable to referral? ☐ Yes ☐ No							
Visual Impairment ☐ Yes ☐ No Speech Impa				ment □ Yes □ No			
Hearing Impairment □ Yes □ No	Hearing Impairment ☐ Yes ☐ No Mobility Aid(s) ☐ Yes ☐ No						
Please specify:							
Reason(s) For Referral							
<ul> <li>□ Recent falls or mobility changes, falls risk</li> <li>□ Recent physical or functional decline</li> <li>□ Unsafe living environment</li> <li>□ Cognitive decline (affecting hygiene, managing</li> <li>□ Responsive behaviours (agitation, wandering, paranoia, hallucinations, inappropriate behaviours)</li> </ul>							
medication, banking, driving and/or meal preparation)							
Emergency Contact							
Name:			Relationship	ationship			
Primary #: Alte	ernate#:		E	Email:			
Power of Attorney (only if applicable)							
POA Type (check all that apply): ☐ Property ☐ Personal Care			POA aware of & agreed to referral ☐ Yes ☐ No				
Name:			Relationship:				
Address:				Postal Code:			
Primary #: Alt	ternate#:		Email:				
Identified Need (check all that apply)							
☐ Assistance with Forms ☐ Community Referrals ☐ Service Coordination ☐ System Navigation ☐ Advocacy ☐ Safety & Wellbeing ☐ Isolation ☐ Self-Neglect <u>Elder Abuse</u> *: ☐ Emotional ☐ Physical ☐ Financial ☐ Sexual ☐ 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)					
<b>Is this individual currently on a wait list for Long-Term Care?</b> □ 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 <u>not</u> 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:					
Date.					

Submit completed forms via

Fax: 519-354-5152
Email: <a href="mailto:tmartin@familyservicekent.com">tmartin@familyservicekent.com</a>

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			

<sup>\*</sup>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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