The Salvation Army
Stepping Stone Supportive Residence
9304-103 A Ave. Edmonton Alberta T5H 4R4
Office: 780-428-4405 FAX: 780-428-4407

INTAKE APPLICATION

IDENTIFICATION

Name: _____
(Surname) *(First)* *(Middle)*

Address: _____
(Apt/Street Number) *(City and Province)* *(Postal Code)*

Phone #: _____
(Home) *(Work)* *(Cell)*

Date of Birth: _____ Gender: _____ Height: _____ Weight: _____
(MM-DD-YYYY)

Religion: _____ Marital Status: _____

PHN (Alberta Health Care #): _____ CPP: _____

SIN: _____ Treaty: _____

Veteran ID: _____ Blue Cross: _____

AISH ID #: _____

Do you Receive Financial assistance for a Mental Health Disability? ☐ YES ☐ NO

Do you Receive Financial assistance for a Medical Disability? ☐ YES ☐ NO

EMERGENCY CONTACT INFORMATION

Primary Contact Name: _____ _____
(Relationship)

Phone #: _____
(Home) *(Work)* *(Cell)* *(Fax)*

Secondary Contact Name: _____ _____
(Relationship)

Phone #: _____
(Home) *(Work)* *(Cell)* *(Fax)*

PERSONAL LEGAL REPRESENTATIVE CONTACT INFORMATION

Guardian Contact Name: _____ Formal ____ Informal ____

Phone #: _____
(Home) *(Work)* *(Cell)* *(Fax)*

Trustee Contact Name: _____ Formal ____ Informal ____

Phone #: _____
(Home) *(Work)* *(Cell)* *(Fax)*

OTHER CONTACT INFORMATION

Lawyer: _____
(Name) *(Phone)* *(Fax)*

Probation/Parole Officer: _____
(Name) *(Phone)* *(Fax)*

Legal Restrictions: ☐ YES ☐ NO Is a copy attached? ☐ YES ☐ NO

Community Treatment Order ☐ YES ☐ NO Is a copy attached? ☐ YES ☐ NO

Not Criminally Responsible ☐ YES ☐ NO Is a copy attached? ☐ YES ☐ NO

AISH Worker: _____
(Name) *(Phone)* *(Fax)*

Family Doctor: _____
(Name) *(Phone)* *(Fax)*

Psychologist/Psychiatrist: Community _____
(Name) *(Phone)* *(Fax)*

Psychologist/Psychiatrist: Hospital _____
(Name) *(Phone)* *(Fax)*

Mental Health Therapist: Community _____
(Name) *(Phone)* *(Fax)*

Mental Health Therapist: Hospital _____
(Name) *(Phone)* *(Fax)*

Enduring Power of Attorney: ☐ YES ☐ NO

If yes: _____
(Name) *(Phone)* *(Fax)*

Informal Support: _____
(Name) *(Phone)* *(Fax)*

Other Contact: _____
(Name) *(Phone)* *(Fax)*

CONSENT FOR RELEASE OF INFORMATION and also RANDOM DRUG/BREATHALYZER SCREENING

I, _____
Name of Applicant (Please Print)

of _____
City or Town

Authorize the Salvation Army supportive Residence to obtain or release information contained in the Salvation Army supportive Residence Intake Application for the purpose of sharing information with the other health profesionals, agencies, or institutions involved in the Assessment/Placement/Treatment process.

I also consent to undergo go random urine and breathalyzer screening for as long as I am in Supportive Residence.

_____ _____
(Applicant's Signature) (Witness Signature)

_____ _____
(Date) (Date)

MEDICAL INFORMATION

Mental Health Diagnosis:

Current medication list including dosage and frequency:

Allergies: ☐ YES ☐ NO If YES please list allergies and reactions:

Relevant Medical History:

Hospitalization: List dates and reason for admissions

Relevant Past Mental Health History:

Hospitalizations: List dates and reason for admissions

Is there a history of any of the following:

Abusive Behaviour	☐ YES ☐ NO	Drug Abuse	☐ YES ☐ NO	Parole/Probation	☐ YES ☐ NO
Anger Management	☐ YES ☐ NO	Sexual Assault	☐ YES ☐ NO	Gambling	☐ YES ☐ NO
Alcohol Abuse	☐ YES ☐ NO	Criminal Record	☐ YES ☐ NO	Suicidal Behaviour	☐ YES ☐ NO

Addictions Treatment Previously received:
Program: Date:

Infectious Disease:

HEP A:	☐ YES	MRSA:	☐ YES	TB:	☐ YES
HEP B:	☐ YES	HIV:	☐ YES	VRE:	☐ YES
HEP C:	☐ YES	CDIFF:	☐ YES	ESBL:	☐ YES

Has the client been screened for any of the above? If yes, please list the date(s) of the last screening(s):

Are there conditions or behaviors that will increase the risk of transmission of infectious material? ☐ YES ☐ NO
If YES please describe:

Immunizations/Investigation:

Vaccination- Flu:	☐ YES ☐ NO	Date:	_____
Vaccination- Pneumovax:	☐ YES ☐ NO	Date:	_____
Chest X-Ray	☐ YES ☐ NO	Date:	_____

CLIENT CHARACTERISTICS

Do you require any assistance or have any concerns or needs with any of the following categories?

Communication:

Sleep:

Eating/Dentition: Special Diets:_____ Food Allergies:_____

Hydration:

Urinary Continence:

Skin Integrity/Bathing:

Mobility/Transferring:
Bus Capable_____ Taxi ____ DATS_____ DATS # _____ Family_____

Circulation and Sensation:

Lab Work Requirement:

Oxygen Therapy: Smoker _____ Safety Issues:_____

Ostomy Care:

Additional Therapies:

Recent Consults/Geriatric Assessments Completed:

Recommended Client Consultation/Follow-Up:

CURRENT LIVING ARRANGEMENT

Briefly describe why placement is required:

FAMILY AND SOCIAL SUPPORTS / LEISURE AND RECREATIONS

Do you have children or dependants? ☐ YES ☐ NO How many children do you have? _____

Do you see them regularly ☐ YES ☐ NO Do you have scheduled visitations? ☐ YES ☐ NO

Who do you spend your time with?

☐ FAMILY ☐ ALONE ☐ FRIENDS ☐ OTHER (Explain)

How do you spend your leisure time?

Do you have any hobbies?

Do you have a job? If so, how often do you work?

Do you have any skills you are proud of?

Is it easy for you to meet new friends? ☐ YES ☐ NO

Are you able to prepare meals? ☐ YES ☐ NO

Are you able to clean? ☐ YES ☐ NO

Any other Comments:

APPLICATION ASSISTANCE AND FOLLOW UP

Did you receive assistance to complete this application? ☐ YES ☐ NO

If yes, who assisted or completed on your behalf? Name: Position:

Agency: Phone:

Will you continue to follow this client if accepted: ☐ YES ☐ NO

If no, indicate who will be following: