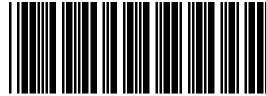
Santé
et Services sociaux
Québec


DT9212

MULTICLIENTELE
INTAKE

DATE		
Year	Month	Day

FOR CLSC USE	
Profil de l'usager	N° de la demande

Date of birth (Year / Month / Day)	Room no.	File no.
First and last name at birth		
Usual name or spouse's name		
Address		
Postal code	Telephone no. (Area code)	Sex: M ☐ F ☐
Health insurance no.	Name of attending physician	

IDENTIFICATION

Name at birth: ______________________ | ______________________
Last name — First name

Sex: ☐ M ☐ F Usual name: ______________________

Permanent address: ______________________
(Place of residence, permanent residence)
No., street, apartment

City: ______________________ Postal code: __________

Telephone no.: ____ | ______ ____ | ______ | ____ E-mail: ______________
Area code — Residence — Area code — Work — Extension

Temporary address: ______________________
(Place of residence, temporary residence)
No., street, apartment

City: ______________ Postal code: __________ Telephone no.: ____ | ______
Area code

Date of birth: ____ | ____ | ____ Age: ______ Place of birth: ______________
Year — Month — Day

Marital status: ☐ Single ☐ Married ☐ De facto spouse ☐ Widowed ☐ Separated ☐ Divorced

Health insurance no.: ____ | ____ | ____ Exp.: ____ | ____ Social insurance no.: ____ | ____ | ____
Year — Month

Language of communication: ☐ French ☐ English ☐ Other: ______________

Cultural community: ______________________

Name of spouse: ______________________ | ______________________
Last name — First name

Date of birth: ____ | ____ | ____ Age: ______
Year — Month — Day

Father's name: ____________ | ____________ Mother's maiden name: ____________ | ____________
Last name — First name — Last name — First name

Resource person: ____________ | ____________ Relationship: ______________
Last name — First name

Telephone no.: ____ | ______ ____ | ______ | ____ E-mail: ______________
Area code — Residence — Area code — Work — Extension

Specify if this person is a(n): ☐ Mandatary ☐ Advisor to a person of full age ☐ Tutor ☐ Curator

Language of communication: ☐ French ☐ English ☐ Other: ______________

Resource person: ____________ | ____________ Relationship: ______________
Last name — First name

Telephone no.: ____ | ______ ____ | ______ | ____ E-mail: ______________
Area code — Residence — Area code — Work — Extension

Specify if this person is a(n): ☐ Mandatary ☐ Advisor to a person of full age ☐ Tutor ☐ Curator

Language of communication: ☐ French ☐ English ☐ Other: ______________

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File no.

IDENTIFICATION (cont'd)

TYPE OF RESIDENCE

	Permanent Place of residence	Temporary (if applicable) Place of residence
1. Residence		
• House	☐	☐
• Apartment	☐	☐
• Subsidized housing	☐	☐
• Room	☐	☐
2. Residence with services		
• Room and board	☐	☐
• Private senior's home with services	☐	☐
• Subsidized housing, coop, nonprofit organization with services as per SHQ-MSSS agreement	☐	☐
• Other, specify:	______	______
Services included in the lease, specify:	______	______
3. Family-type resource (FTR)	☐	☐
4. Intermediate resource (IR)	☐	☐
5. CHSLD	☐	☐
6. Other (hospital, rehabilitation centre, detention centre, etc.), specify:	______	______

LIVING SITUATION

☐ Single person

☐ Childless couple

☐ Couple with children under 18

☐ Single parent family

☐ Two people or more

○ With relatives

○ With non-relatives

Specify:

• If there are children under 18

______

• If there are adults with permanent or temporary disabilities

______

OCCUPATION

☐ Employed ☐ Student ☐ At home ☐ Other: ______

SOURCE OF REQUEST

REQUESTED BY

☐ User ☐ Family member or friend ☐ Community ☐ Practitioner ☐ Other

Name: ______ (Last name) ______ (First name) Telephone no.: ______ (Area code) ______ (Extension)

Profession: ______ Name of establishment: ______

Is this the first request? ☐ Yes ☐ No ☐ Don't know

Services already received: ______

Reasons: ______

______ Year: ______

User consents to release information on him/herself: ☐ Yes ☐ No

Specify: ______

STUDY OF REQUEST

NATURE OF REQUEST (expectations of the user and the person handling the request, medical prescription)

______

Medical prescription: ☐ At home ☐ Pending

File no.

INTAKE

PROBLEMS OR FACTORS LEADING TO THE REQUEST (bio-psychosocial – specify diagnosis and antecedents – or linked to living habits, activities of daily living (ADL), domestic tasks, etc.)

MEDICAL INFORMATION

Hospitalization
(date of most recent stay): from ____ Year | Month | Day to ____ Year | Month | Day

Number of times in the past year: ____

Name of establishment: ____

Reasons: ____

Followup: Name/Specialty	Hospital/Clinic/Address	Next appointment Year / Month / Day

Attending physician: ____ Telephone no.: ____ Area code

Family doctor: ____ Telephone no.: ____ Area code

Address: ____ Fax no.: ____ Area code

Notified on: ____ Year | Month | Day

Location of followup: ☐ Home ☐ Office/Clinic ☐ CLSC ☐ FTR[1] ☐ IR[2] ☐ CHSLD[3] ☐ Other

Medication:

Name	Dose and frequency

Name of pharmacy: ____ Telephone no.: ____ Area code

Allergies: ____

Prognosis: ____

[1] Family-type resource [2] Intermediate resource [3] Residential and long-term care centre

File no.

INTAKE

PREVIOUS STEPS OR SERVICES REQUESTED OR IN PROGRESS
(what has already been done to address the situation, where, and by whom)

CURRENT RESOURCES (help, services, financial resources)

Family, entourage (actual or potential involvement):

Community, public, and private services:

Protective supervision: ☐ No ☐ Yes, specify: ☐ Advisor to a person of full age ☐ Tutor ☐ Curator

Paying agent: ☐ No ☐ Yes, specify:
☐ Personal insurance ☐ Government programs (CSST, SAAQ, Veterans Affairs, etc.)
☐ Other:

REMARKS AND OTHER INFORMATION

IDENTIFICATION OF RISK FACTORS

Disabilities involving:

☐ Mobility
☐ Communication
☐ Activities of daily living (ADL)
☐ Domestic tasks

Health problems:

☐ That aggravate the disabilities or the situation
☐ That must be resolved through short term care

Vulnerability or danger factors:

☐ Advanced age
☐ Exploitation
☐ Bereavement or loss
☐ Socioeconomic factors
☐ Other:
☐ Risk of suicide
☐ Violence
☐ Abuse

Known problems:

☐ Drug abuse
☐ Drug addiction ☐ Alcoholism
☐ Other:

Psychosocial situation:

☐ Isolation, insecurity
☐ Absence of community and public resources
☐ Limited or non existent natural support
☐ Caregiver is strained, tired, exhausted
☐ Other:

User is able to live alone:

☐ Yes
☐ No, specify:

Reasons:

File no.

INTAKE

DECISION

☐ Request inadmissible

○ No referral ○ Referral to another resource or program

Specify: ____________________

☐ Request admissible

☐ Request is without priority due to the lack of resources: ____________________

○ No referral ○ Referral to another resource ○ Follow-up

Specify where and why: ____________________

☐ Request granted for assessment by a(n):

○ Nurse ○ Psychosocial worker ○ Doctor ○ Occupational therapist

○ Physiotherapist or physical readaptation therapist ○ Other: ____________________

PRIORITY TO ASSESS SITUATION

☐ **Priority 1** – Immediately
Crisis situation
Imminent danger to the health and safety of user or family and friends
Imminent risk of hospitalization or placement if no service is given

☐ **Priority 2** – Within 48 hours
Potential crisis situation
Potential danger to the safety of user and family or friends
Risk of very short-term deterioration (biopsychosocial)
Risk of short-term hospitalization or placement if no service is given
Very short-term intervention by a nurse is necessary

☐ **Priority 3** – Within one week
No perceived crisis or danger
No risk of short-term deterioration (biopsychosocial)
Low risk of premature hospitalization or placement
Caregivers becoming exhausted
Short-term intervention by a nurse is necessary

☐ **Priority 4** – Within two weeks
User is safe
Low foreseeable risk of deterioration
Caregivers can compensate temporarily

Date to be assessed by: ____ Year ____ Month ____ Day **or** Date of first visit: ____ Year ____ Month ____ Day

STEPS TAKEN AT TIME OF CONTACT AND RECOMMENDATIONS
(medical supplies, technical aids, equipment issued, etc.)

____

____

____

____

____

____

Signature __________ Title __________ Date: Year ____ Month ____ Day ____

Follow-up: ____________________

____

____

____

____

Signature __________ Title __________ Date: Year ____ Month ____ Day ____