Total Home & Health Care Services

Service Request Form

Assessment Date: _____ Claim No.: _____

Re-assessment Date (if available): _____

Client Information
First Name: _____ Last Name: _____ DOB: _____ Gender: M / F

Address: _____ City: _____ Province: ____ Postal Code: _____

Tel.: _____ Primary Language: _____

Contact Person
First Name: _____ Last Name: _____

Tel.: _____ Alt Tel.: _____

Contact Instructions:

Insurance Information
Company Name: _____

Name of Adjuster: _____ Tel.: _____ Ext. _____

Occupational Therapist Information
Company Name: _____

Name of OT: _____ Tel.: _____ Ext. _____

Client Health Information
Does the Client have:

- ☐ Respiratory Illness
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Other: _____
- ☐ Brain Injury
- ☐ Emphysema
- ☐ Chronic Bronchitis
- ☐ Drug Allergy
- ☐ Food Allergy
- ☐ Orthopaedic Injury(ies) _____

Service Request
Form One - Monthly Allowance for Attendant Care: Duration _____ weeks Amount: $_____

Monthly Allowance for Housekeeping: Duration _____ weeks Amount: $_____

Personal Support/Homemaking Services

Personal Care
- ☐ Bathing
- ☐ Toileting
- ☐ Personal Hygiene
- ☐ Dressing
- ☐ Feeding
- ☐ Other: _____

Housekeeping
- ☐ Meal Preparation
- ☐ Shopping
- ☐ Light Cleaning
- ☐ Vacuuming/Mopping
- ☐ Laundry
- ☐ Other: _____

Special Instructions

The Client needs the following equipment:
- ☐ Bath Bench
- ☐ Bath Mat
- ☐ Other: _____
- ☐ Hand Held Shower
- ☐ Grab bars
- ☐ Bathtub Grab bar
- ☐ Raised Toilet Seat

Times and Dates Service is to be Provided

	M	T	W	W	T	F	S	S
Hours Per Day								

Start Date mm/dd/yy _____

Duration of Service _____ weeks

Requested by: ----------Signature ----------

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