APPLICATION OF ADMISSION

ADULT SERVICES

IMAGINE THERAPEUTIC SERVICES

IDENTIFYING INFORMATION

DATE: _____

FIRST NAME		LAST NAME	
STREET/MAILING ADDRESS			
CITY & PROVINCE	POSTAL CODE	PHONE NUMBER	CONTACT NUMBER
DESCRIPTION	HEIGHT	WEIGHT	HAIR
	BUILD	EYES	DISTINGUISHING MARKS
CITIZENSHIP STATUS		DOB (M/D/Y)	AGE
PREFERRED PLACEMENT DATE			

☐ FEMALE

☐ MALE

HEALTH CARD NUMBER	SOCIAL INSURANCE NUMBER
BAND	STATUS CARD NUMBER
EDUCATION PROGRAM IF APPLICABLE	EMPLOYMENT STATUS (i.e. Unemployed, Full or Part-Time Student, Ontario Works, ODSP, etc.)
PREFERRED LANGUAGE	

REFERRAL SOURCE INFORMATION

NAME OF REFERRING PERSON	POSITION
AGENCY NAME/CAREGIVER AND ADDRESS	
PHONE NUMBER 1	PHONE NUMBER 2
NATURE OF RELATIONSHIP WITH THE CLIENT (i.e. counselor, advocate, family, doctor, etc.)	
REASON FOR INVOLVEMENT WITH REFERRING PERSON/AGENCY	
GIVE A BRIEF DESCRIPTION OF THE CLIENT'S NEEDS (PHYSICAL, PROGRAM, INTERESTS HOBBIES)	
LIST THE PROGRAMS AND/OR SERVICES CLIENT IS CONNECTED TO	

FAMILY CONTACT INFORMATION

NAME	RELATIONSHIP	CONTACT NUMBER

MENTAL HEALTH HISTORY

PSYCHIATRIC HISTORY: OUTPATIENT TREATMENT ☐ **YES** ☐ **NO** If yes, fill in description below:

TREATMENT PROVIDER	REASON FOR TREATMENT	NATURE OF TREATMENT	DATE

PSYCHIATRIC HOSPITALIZATION: ☐ **YES** ☐ **NO** If yes, fill in description below:

WHERE	REASON	DATE

OTHER SUPPORT SERVICES:
Other than contacts listed on Medical Information (e.g. psychologists, psychiatrists)

NAME OF SERVICE SUPPORT	ADDRESS & PHONE NUMBER

CURRENT CONCERNS:

MEDICAL HISTORY

LIST ANY AND ALL MEDICATION BELOW:

NAME AND DOSAGE:	PRESCRIBED BY:	REASON PRESCRIBED:	DATE STARTED:

DOES CLIENT HAVE ANY ALLERGIES? ☐ **YES** ☐ **NO** (IF YES, PLEASE LIST BELOW)

IS AN EPI-PEN REQUIRED FOR ANY OF THE ABOVE ALLERGIES? ☐ **YES** ☐ **NO**

DO YOU HAVE ANY OF THE FOLLOWING? (Please check all that apply)

☐ ARTHRITIS	☐ ASTHMA	☐ BOWEL PROBLEMS
☐ EAR/HEARING PROBLEMS	☐ EYE PROBLEMS	☐ STOMACH PROBLEMS
☐ TUBERCULOSIS	☐ HEART DISEASE	☐ BLOOD PRESSURE
☐ HERNIA	☐ DIABETES	☐ CANCER
☐ CONVULSIONS/SEIZURES	☐ HEAD INJURY	☐ PREGNANCY

ANY MAJOR CLIENT HEALTH CONCERNS NOT LISTED

MEDICAL HISTORY (CONTINUED)

VALID ONTARIO HEALTH CARD? ☐ YES ☐ NO #_____ VC:_____

DO YOU HAVE A BIRTH CERTIFICATE? ☐ YES ☐ NO

DATE OF LAST PHYSICAL: _____ DOCTOR'S NAME:	PH: ADDRESS:
DATE OF LAST DENTAL: _____ DENTIST'S NAME:	PH: ADDRESS:
DATE OF LAST EYE EXAM: _____ OPTOMETRIST'S NAME:	PH: ADDRESS:

EMERGENCY MEDICAL TREATMENT PERMISSION

I/WE HEREBY AUTHORIZE THE DIRECTORS OF IMAGINE THERAPEUTIC SERVICES OR THEIR AGENTS TO OBTAIN MEDICAL TREATMENT FOR _____.
NAME OF CLIENT

_____
NAME OF PARENT/LEGAL GUARDIAN

_____
SIGNATURE OF PARENT/LEGAL GUARDIAN

_____
SIGNATURE OF CLIENT (IF APPLICABLE)

_____
DATE SIGNED

LEGAL STATUS & HISTORY

CURRENT/PENDING CHARGES:	☐ YES ☐ NO	LIST CHARGE(S):	
IN JAIL:	☐ YES ☐ NO	RELEASE DATE:	
ON PROBATION:	☐ YES ☐ NO	START DATE:	END DATE
CONDITION(S):			
ON PAROLE:	☐ YES ☐ NO	START DATE:	END DATE
CONDITION(S):			
ANY OUTSTANDING COURT DATE	☐ YES ☐ NO	DATE:	REASON:
PROBATION/PAROLE OFFICER:		ADDRESS:	TELEPHONE NUMBER:
HISTORY OF PAST OFFENCES			

FUNDING INFORMATION

FUNDING SOURCES APPLICABLE	☐ YES ☐ NO	START DATE:	END DATE:

SELECT ALL THAT APPLY:

☐ **ODSP** ☐ **MINISTRY FUNDING** ☐ **CAS FUNDING**

☐ **PASSPORT** ☐ **URGENT RESPONSE** **OTHER :**