

# Service Request Form

Assessment Date: \_\_\_\_\_ Claim No.: \_\_\_\_\_  
 Re-assessment Date (if available): \_\_\_\_\_

<b>Client Information</b>			
First Name: _____	Last Name: _____	DOB: _____	Gender: M / F
Address: _____	City: _____	Province: _____	Postal Code: _____
Tel.: _____	Primary Language: _____		
<b>Contact Person</b>			<b>Contact Instructions:</b>
First Name: _____	Last Name: _____		
Tel.: _____	Alt Tel.: _____		

**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:

<input type="checkbox"/> Respiratory Illness	<input type="checkbox"/> Brain Injury	<input type="checkbox"/> Drug Allergy
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Food Allergy
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Orthopaedic Injury(ies) _____
<input type="checkbox"/> Other: _____		

**Service Request**

Form One - Monthly Allowance for Attendant Care: Duration \_\_\_\_\_ weeks Amount: \$ \_\_\_\_\_  
 Monthly Allowance for Housekeeping: Duration \_\_\_\_\_ weeks Amount: \$ \_\_\_\_\_

**Personal Support/Homemaking Services**

<b>Personal Care</b> <input type="checkbox"/> Bathing <input type="checkbox"/> Toileting <input type="checkbox"/> Personal Hygiene <input type="checkbox"/> Dressing <input type="checkbox"/> Feeding <input type="checkbox"/> Other: _____	<b>Housekeeping</b> <input type="checkbox"/> Meal Preparation <input type="checkbox"/> Shopping <input type="checkbox"/> Light Cleaning <input type="checkbox"/> Vacuuming/Mopping <input type="checkbox"/> Laundry <input type="checkbox"/> Other: _____
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**The Client needs the following equipment:**

<input type="checkbox"/> Bath Bench	<input type="checkbox"/> Hand Held Shower	<input type="checkbox"/> Bathtub Grab bar
<input type="checkbox"/> Bath Mat	<input type="checkbox"/> Grab bars	<input type="checkbox"/> Raised Toilet Seat
<input type="checkbox"/> Other: _____		

**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

**Special Instructions**