



BG Support Care Services

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51 Gladstone Ave, Hamilton, Ontario L8M 2H7

TEL: 289 933 0730 E-MAIL: bgsc.services@gmail.com

WEB: bgscareservices.com

Today's Date ____/____/20____ Time ____:____
DAY / MONTH / YEAR AM / PM

Client Information

First Name _____ Last Name _____

Address _____ City _____ Postal Code _____

E-mail _____ Cell Phone _____ Date of Birth _____

Diagnosis _____ Anticipated Discharge Date _____

Discharge instructions _____

Current Care Setting _____

Primary Doctor _____ City _____ Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Referral Information

Contact _____ Title _____ Phone _____

Follow-up Requested _____

Select Services Needed:

Companion

- Support, friendship, socialization
- Overall monitoring of well-being
- Encourage/assist in participation with social activities
- Assist with correspondence with family and friends
- Alzheimer's Care
- Respite Care for family members
- Hospital Sitting
- Other _____

Personal Assistance

- Bathing, toileting, personal hygiene assistance
- Grooming and dressing supervision
- Ambulation assistance/fall prevention
- Medication reminders
- Meal planning/preparation
- Laundry/bed linens
- Light housekeeping
- Assistance with pet care
- Shopping/errands
- Transportation to appointments, etc.
- Other _____

Medical

- Medication management services
- Hands-on assistance with transfers and mobility
- Delegated nursing tasks to caregivers
- Other

Case Management

- Identifying/coordinating resources & services
- Coordinating/attending appointments
- Hospital visits/discharge planning
- Relocation assistance
- 24/7 emergency availability
- Crisis intervention
- Assessments/consultations
- Advocacy/education
- Assist with health care advanced directives
- Act as Health Care Agent
- Provide Case Management reports
- Other _____