



NEAR NORTH PALLIATIVE CARE NETWORK

347 Sherbrooke Street, Suite 302, North Bay, Ontario, P1B 2C1
 Phone: (705) 497-9239 1-800-287-9441 Fax: (705) 497-1039
 Mattawa: 705-744-3771 Sturgeon-Falls: 705-753-5771
 E-mail: office@nnpcn.com Website: www.nnpcn.com

CLIENT APPLICATION FORM

Date: (MM/DD/YYYY)

PART I. GENERAL INFORMATION:

Client's Last Name: Client's First Name:
 Phone #: Date of Birth (MM/DD/YYYY):
 Mailing Address:
 City: Province: Postal Code:

<p>Are you the client? YES <input type="checkbox"/> NO <input type="checkbox"/> If NO, specify your name, phone number and relationship to the client you represent: Name: Phone number: Relationship to the client:</p>	<p>Is the client* currently being seen by a health care professional? YES <input type="checkbox"/> NO <input type="checkbox"/> (* The client = you or the client you represent) If YES, specify the name and area of specialization of the health care professional:</p>
<p>What are you looking for?</p> <p>Telephone Support <input type="checkbox"/></p> <p>Palliative Care Services <input type="checkbox"/></p> <p>Respite Services <input type="checkbox"/></p> <p>Bereavement Individual Session <input type="checkbox"/></p> <p>Bereavement Group Session <input type="checkbox"/></p> <p>Information <input type="checkbox"/></p> <p>Medical Loan Cupboard <input type="checkbox"/></p> <p>Lending Library <input type="checkbox"/></p> <p>Education and Training <input type="checkbox"/></p> <p>Other (specify): <input type="checkbox"/></p> <p>Best time to contact you: Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/></p>	<p>Health care services being provided to you/to the client:</p> <p>Medical Care <input type="checkbox"/></p> <p>Social Worker Support <input type="checkbox"/></p> <p>Palliative Care Services <input type="checkbox"/></p> <p>Respite Services <input type="checkbox"/></p> <p>Home Support Services <input type="checkbox"/></p> <p>Bereavement Individual Sessions <input type="checkbox"/></p> <p>Grief Information Evenings <input type="checkbox"/></p> <p>Grief Self-Help Support Group <input type="checkbox"/></p> <p>Support Group <input type="checkbox"/></p> <p>Still on waiting list <input type="checkbox"/></p> <p>Other (specify): <input type="checkbox"/></p>

How did you hear about our service? Brochure Family Friend Website

Other (specify):

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PART II. If you are looking specifically for Bereavement and Grief Services please fill the information below:

Name of the Deceased:

Date of Death (MM/DD/YYYY):

1. Your relationship to the Deceased:

- Wife
- Husband
- Daughter
- Son
- Sister
- Brother
- Mother
- Father
- Friend
- Other Specify:

2. Nature of Death:

Unexpected Expected

Illness/Long Term Specify:

Suicide Specify:

Crime Specify:

Accident (vehicle, work related, fire, etc) Specify:

Child Death Specify:

Stillbirth

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NNPCN Website Client Application Form (print format)