Centre intégré
de santé
et de services sociaux
de la Montérégie-Ouest
Québec

Facility: _____

File: _____

Name, first name: _____

Date of birth: ____ / ___ / ____ ❑ F ❑ M
year month day

Mother's name: _____

Father's name: _____

DATA COLLECTION OF CLSC FIRST-LINE NURSING

SECTION TO BE COMPLETED BY THE PATIENT

Date: YEAR/MONTH/DAY

Who referred you to the CLSC: _____

Name of your doctor or SNP*: _____ Telephone: _____

Names of medical specialists: _____ Telephone: _____

_____ Telephone: _____

Other health professionals:

☐ Nutritionist ☐ Occupational therapist

☐ Physiotherapist ☐ Other: _____

What is your current health problem? _____

Person to contact in case of emergency: _____ Telephone: _____

Are you receiving any CLSC services? ☐ Yes ☐ No Specify: _____

Have you been hospitalized during the last year? (If yes, which hospital and why?)

☐ Yes ☐ No Specify: _____

If Yes, are you a carrier of any multiple resistant bacteria? (MRSA, VRE, C difficile, KPC)

☐ Yes ☐ No Specify: _____

Do you have allergies?

☐ Yes ☐ No Specify : _____

Name of your pharmacy: _____ Telephone: _____

☐ Private insurance ☐ SAAQ ☐ CNESST Other: _____

* SNP Specialized nurse practitioner

Health history and current diagnosis

Do you suffer from digestive disorders? (constipation, diarrhea, nausea, pain)

☐ Yes ☐ No Specify: _____

Do you have genitourinary problems? (pain, urinary or gynecological problems)

☐ Yes ☐ No Specify: _____

Do you have breathing problems? (pain, cough, sputum)

☐ Yes ☐ No Specify: _____

Do you have cardiac problems?

☐ Yes ☐ No Specify: _____

_____

Surgical history

☐ Yes ☐ No Specify: _____

Treatments or special care, including the reason for this consultation

Do you have trouble mobilizing? ☐ Yes ☐ No Specify: _____

Do you need help with walking? ☐ Yes ☐ No ☐ Ordinary cane ☐ Tripod cane ☐ Quad cane ☐ Walker

Do you have pain? ☐ Yes ☐ No Specify: _____

_____

Autonomy

Are you able to do your daily activities and domestic chores?

☐ Yes ☐ No Specify: _____

Lifestyle

Do you sleep well? ☐ Yes ☐ No Specify: _____

Do you have a special diet? ☐ Yes ☐ No Specify: _____

Do you have eating problems? ☐ Yes ☐ No

Remarks: _____

Number of glasses of water per day? ☐ 0 to 3 ☐ 4 to 5 ☐ 6 to 8

Do you smoke? ☐ Yes ☐ No Specify: _____

Do you consume alcohol or drugs? ☐ Yes ☐ No Specify: _____

Religion/belief system: _____

Psychosocial status

Do you live alone? ☐ Yes ☐ No

Do you have a caregiver? ☐ Yes ☐ No Specify : _____

Do you have any financial or transportation problems?

☐ Yes ☐ No Specify: _____

☐ **I consent that the information contained in this form may be disclosed to CISSS de la Montérégie-Ouest health professionals and/or to my family doctor/SNP/medical specialist.**

☐ **I attest that my legal representative or I have completed the information and that all the data and information are up to date and complete to the best of my knowledge.**

Date : YEAR/MONTH/DAY Signature of patient/representative: _____

SECTION MUST BE COMPLETED BY NURSE

Medical history ☐ Yes ☐ No

☐ Angina	☐ Hypercholesterolemia	☐ COPD/Asthma
☐ Sleep Apnea	☐ Hypertension	☐ Cancer: _____
☐ Arthritis	☐ Hypothyroidism	☐ Mental problems
☐ CVA (stroke)	☐ Infarct	☐ Osteoporosis
☐ Diabetes	☐ CAD (Coronary artery disease)	☐ Other: _____
☐ Atrial Fibrillation		

Medications

Do you know your medication? ☐ Yes ☐ No

☐ Print-out of pharmacological profile on the DSQ

☐ If the pharmacological profile is not available on the DSQ, advise the patient to bring their pharmacological profile on the next visit.

BP	PULSE	RESP	O^2 SAT	Tº	WEIGHT	GAIN or LOSS	HEIGHT	BLOOD GLUCOSE
Notes:								

Flu Vaccine: _____

References

☐ Diabetes Clinic ☐ Smoking cessation ☐ HCS ☐ Asthma/MPOC

☐ Oncology ☐ Psychosocial ☐ Other: _____

Any particularities/Health particularities (dressing, O^2, tube feeding, dialysis, etc.):

_____

Registration for 24/7: ☐ Yes

Fall prevention

1. Have you had one or more falls over the past year? ☐ Yes ☐ No

   If Yes, how many falls did you have? _____

2. Do you have problems with walking or balance? ☐ Yes ☐ No

3. Are you afraid of falling? ☐ Yes ☐ No

If over 2 positive answers, fall prevention pamphlet given to patient

Date : YEAR/MONTH/DAY Signature of nurse: _____