

## Personal Profile – Adult Services

---

**MEDICATION ALERT:**  Yes  No

(If Yes, see medical notes)

**GOALS OF CARE  
DESIGNATIONS:**  Yes  No

Name: \_\_\_\_\_  
(First) (Middle) (Last)

Phone (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_

Street Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
(Street or Box #) (Town) (PC)

Date of Birth: \_\_\_\_\_  
(Month) (Day) (Year)

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Other distinguishing features: \_\_\_\_\_

Method of communication: \_\_\_\_\_

Personal Health #: \_\_\_\_\_ Social Insurance #: \_\_\_\_\_

Medical Services #: \_\_\_\_\_ Other Insurance: \_\_\_\_\_

Band #: \_\_\_\_\_ Treaty #: \_\_\_\_\_

Authorized Restrictive Procedures:  Yes  No

Medical Diagnosis (e.g. diabetes, epilepsy): \_\_\_\_\_

Medical History and Relevant Information: \_\_\_\_\_

Allergies: (Medicine, food, other): \_\_\_\_\_

	Name	Address	Phone
<b>Physician</b>			
<b>Optometrist</b>			
<b>Dentist</b>			
<b>Specialist</b>			

Binder(s):	Adult Services	Page: 1 of 2			
Section(s):	Entry/Exit	R	95-04	R	98-05-03 R/R
Program Area(s):	Adult Disability				

**Personal Profile – Adult Services Continued . . .**

<b>Contacts</b>	<b>Name</b>	<b>Address</b>	<b>Email</b>	<b>Phone</b>
Emergency Contacts (Include Next of Kin)				
Guardianship <input type="checkbox"/> Yes <input type="checkbox"/> No				

**Areas of Guardianship (as per Court Order):**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Legal proceedings | <input type="checkbox"/> With whom to consort                    | <input type="checkbox"/> Health Care                 |
| <input type="checkbox"/> Where to live     | <input type="checkbox"/> License/permits/consents                | <input type="checkbox"/> Education/Vocation/Training |
| <input type="checkbox"/> With whom to live | <input type="checkbox"/> Diet, dress, day-to-day decisions       | <input type="checkbox"/> Employment                  |
| <input type="checkbox"/> Other: _____      | <input type="checkbox"/> Supported Decision Making Authorization | <input type="checkbox"/> Co-decision-making order    |

<b>Trusteeship</b>	<b>Name</b>	<b>Address</b>	<b>Email</b>	<b>Phone</b>
<input type="checkbox"/> Legal				
<input type="checkbox"/> Informal				
<input type="checkbox"/> Not Applicable				
<b>Agency Contact(s)</b>				
Manager:				
Coordinator:				

**Other Pertinent Information:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Other Involved Services/Agencies:** \_\_\_\_\_

**Completed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Binder(s):	Adult Services	Page: 2 of 2					
Section(s):	Entry/Exit	R	95-04	R	98-05-03	R/R	Apr 26/18
Program Area(s):	Adult Disability						