LiUNA!care
LOCAL 183
BUILDING HEALTHY FUTURES

LiUNA Local 183
Members Benefit Fund

NURSING CARE

LiUNA LOCAL 183
MEMBERS BENEFIT FUND

NURSING CARE

SUBMISSION INSTRUCTIONS:

- Section 1 & 4 to be completed and signed by Member (or Power of Attorney).
- Section 2 to be completed and signed by your Physician.
- Section 3 to be completed and signed by your Case Manager.
- Policy No. 158000. Please keep a copy of completed application package for your records to substantiate your claim.
- Send all original completed applications to:

LiUNAcare Local 183
200 Labourers Way
Suite 2100
Vaughan ON L4H 5H9

Tel: 416-240-7487
Fax: 416-240-7488
Toll Free Line:
1-888-790-3534 Email:
info@liunacare183.com

NURSING CARE HEALTH ASSESSMENT FORM

Once complete, return this form to:

Mail to: LiUNAcare LOCAL 183
2100-200 Labourers Way
Vaughan, ON, L4H 5H9

INSTRUCTIONS FOR COMPLETION

This form ***must be completed in full*** to avoid a delay in assessing the claim. Once we have all the required information and have assessed the claim, we will notify the claimant in writing regarding plan coverage and the number of eligible hours.

Fees for providing medical information are not payable by your plan.

If you have questions, please refer to your Canada Life employee benefits booklet or call 416.240.7487.

Part 1 PATIENT INFORMATION to be completed IN FULL by plan member

Plan Number: _____ Plan Member I.D. Number: _____

Patient Name: _____ Phone Number: _____
Last name First name

Patient Address _____
Number and street Apt. number City or town Province Postal Code

Date of Birth _____
Month Day Year

Language preference: ☐ English ☐ French

Correspondence preference: ☐ Letter mail ☐ Email

Email address: _____@ _____ (illegible writing will default communication to letter mail)

Has a previous application for nursing benefits or health assessment form been submitted? ☐ Yes ☐ No

Other Insurance? ☐ Yes ☐ No

If "Yes", name of insurance company _____ Plan number _____

If you have been approved for nursing under another plan/government program aside from provincial home care; please provide us with a copy of this approval.

Part 2 CURRENT MEDICAL INFORMATION to be completed by physician (please print clearly)

(If additional space is required, please attach a separate sheet. Ensure writing is legible)

Current Diagnosis _____

Past Medical History _____

Prognosis _____

Surgical procedures and dates _____

Condition classified as ☐ Acute ☐ Chronic ☐ Convalescent ☐ Palliative ☐ PPS Score _____

Condition classified as ☐ Unstable/unpredictable ☐ Stable/predictable

Level of Care recommended

☐ RN (Physician must specify details in nursing treatments section)

☐ RPN / LPN (Physician must specify details in nursing treatments section)

☐ HCA/ / PSW (Describe below)

☐ Homemaker (Describe below)

Part 2 CURRENT MEDICAL INFORMATION to be completed by physician (please print clearly) (Con't)

Details of HCA / PSW / Homemaker requirements (non-nursing duties)

_____

_____

Details of nursing (RN/RPN/LPN/RNA) treatments: dressings, injections, etc. (must be specific to nursing care requested)
***Reminder: These duties cannot be those which can be completed by (HCA / PSW / Homemaker)**

1. _____
2. _____
3. _____
4. _____

Current medications: route, dose, frequency

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

CHECK OR COMMENT ON ALL THAT APPLY:

Vital signs: BP _____ Pulse _____ Resp. _____ Temp _____ O2 sats _____

Pain/discomfort Location 1: _____ **Pain/discomfort Location 2:** _____

Frequency _____ Frequency _____

Duration _____ Duration _____

Alleviated by _____ Alleviated by _____

Precipitating factors _____ Precipitating factors _____

Integument

☐ No skin problems ☐ Lesion ☐ Rash ☐ Callous ☐ Bruise ☐ Ulcer ☐ Discharge ☐ Varicosity ☐ Skin breakdown

If yes, explain _____

Oral cavity Special diet ☐ Yes ☐ No Type: _____

☐ No reported concerns ☐ Difficulty chewing ☐ Difficulty swallowing ☐ Dentures: ☐ Upper ☐ Lower

☐ Other _____

Neurological/cognitive levels Level of consciousness ☐ Alert ☐ Altered

☐ Seizures ☐ Fainting ☐ MMSE Score: _____ Date: _____ ☐ Tremors ☐ Spastic

☐ Cognition/Orientation: Difficulty ☐ Yes ☐ No If yes, please explain: _____

☐ Other _____

Respiratory/cardiovascular

☐ S.O.B. ☐ Rest or activity ☐ Orthopnea Cough: ☐ Non-productive ☐ Productive

☐ Cyanosis ☐ Wheezes ☐ Crackles Oxygen use ☐ Continuous ☐ Intermittent ☐ Rate _____

☐ Nebulization ☐ Ventilator ☐ Tracheotomy

☐ Other _____

Cardiovascular - Chest pain? ☐ Yes ☐ No (If yes, please explain) _____

History of: ☐ Hypertension ☐ Hypotension ☐ Dizziness

If yes, explain aggravating factors / remarks: _____

Circulation Difficulty? ☐ Yes ☐ No (If yes, please explain) _____

☐ Edema: ☐ Pitting ☐ Dependent ☐ Right ☐ Left ☐ Bilateral

Gastrointestinal system

☐ Bleeding ☐ Ostomy ☐ GI upset ☐ Diarrhea Appetite ☐ Good ☐ Poor

☐ Constipation ☐ Nausea/vomiting ☐ Gastrostomy/enteral tube

☐ Other _____

Vision

☐ No reported visual loss ☐ Blind ☐ Cataracts ☐ Partially impaired (details) _____

Hearing/ears

☐ No hearing loss ☐ Hearing device ☐ Deaf ☐ Partially impaired (details) _____

Musculoskeletal

☐ No reported concerns

☐ Coordination/Balance _____ ☐ Swollen joints _____

☐ Prosthesis R/L _____ ☐ Limited R.O.M. _____

☐ Amputation R/L _____ ☐ Other _____

Genital/Urinary

☐ Full control _____ ☐ Frequency _____

☐ Incontinence _____ ☐ Blood in urine _____

☐ Difficulty urinating _____ ☐ Nocturia _____

☐ Indwelling catheter _____ ☐ Other _____

Activities of daily living

Adaptive Equipment used at Home:

☐ Cane ☐ Wheelchair ☐ Hospital bed ☐ Eating aids ☐ Standard walker ☐ Wheeled walker ☐ Commode ☐ Toilet aids ☐ Lift

☐ Tub aids ☐ None ☐ Other _____

☐ Independent _____

☐ Requires assistance with: ☐ Mobility ☐ Feeding ☐ Hygiene ☐ Dressing ☐ Toileting ☐ Other

Assistance provided by: _____

Physician name (print) _____ Phone number _____

Address _____
Number and street City or town Province Postal Code

Signature _____ Date _____

Part 3 CONFIRMATION OF PROVINCIAL HOME CARE ENTITLEMENT to be completed by provincial coordinator

Please be advised that this document will enable the nursing specialist at Canada Life to expedite your claim in an efficient and accurate manner. Please have your homecare case co-ordinator / manager fill this out.

Patient Name: _____

Canada Life Policy Number: _____ Canada Life ID Number: _____

Homecare Manager Name: _____ Phone Number: _____

Case Manager: Please provide the current level of care patient is receiving.

Home Support Workers (*Circle HCA PSW HOMEMAKERS) - hourly

Frequency _____ Focus of intervention _____

Treatment end date _____ Max hours reached? ☐ Yes ☐ No

Nurse Practioner Visits

Frequency _____ Focus of intervention _____

Treatment end date _____ Max hours reached? ☐ Yes ☐ No

Nursing (*Circle RN LPN RPN RNA)

☐ Home visits only - Frequency _____ Focus of intervention _____

☐ Shifts in home - Frequency _____ Focus of intervention _____

Treatment end date _____ Max hours reached? ☐ Yes ☐ No

Palliative Pain & Symptom Management

Frequency _____ Focus of intervention _____

Treatment end date _____ Max hours reached? ☐ Yes ☐ No

Case Manager Signature _____ Date _____

Part 4 AUTHORIZATION to be completed by the plan member and patient

At Canada Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. I authorize Canada Life, any healthcare or dentalcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Canada Life located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

I also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com

Plan Member Name _____ Signature _____

Patient Name _____ Signature _____

Date _____