# RESETTLEMENT NEEDS ASSESSMENT FORM

| Family name: | UCI: |
|---|---|
| First name: | IME no. |
| Date of birth (YYYY-MM-DD) | ☐ Male ☐ Female |

There are no special travel requirements or settlement issues. ☐

## 1. FUNCTIONAL ASSESSMENT

| Yes | No | | | | | |
|---|---|---|---|---|---|---|
| ☐ | ☐ | Hearing impairment | ☐ Partial | ☐ Complete | | |
| ☐ | ☐ | Vision impairment | ☐ Partial | ☐ Complete | | |
| ☐ | ☐ | Speech impairment | ☐ Partial | ☐ Complete | | |
| ☐ | ☐ | Cognitive impairment | ☐ Mild | ☐ Moderate | ☐ Severe | |
| ☐ | ☐ | Mobility impairment ▶ | Current mobility aid: _____ | Mobility aid required: _____ | | |
| ☐ | ☐ | Other impairment (list below and describe if possible: Example - feeding due to dental condition) | | | | |

Details

Activities of daily living ☐ Independent ☐ Partial care ☐ Total care

Details

## 2. SPECIAL TRAVEL REQUIREMENTS

☐ None ☐ Wheelchair ☐ Stretcher ☐ Medical escort required ☐ Other

Details

## 3.POST-ARRIVAL SERVICES REQUIRED

☐ No services required

☐ Consultation with a health care professional required ▶ ☐ Urgent (72 hrs) ☐ Within ___ weeks ☐ As required ☐ Specialized services ☐ Long term services

Details

## 4. HOUSING AND DAILY ACTIVITIES / ASSISTANCE REQUIREMENTS

☐ Fully independent, no assistance required

☐ Wheelchair access required

☐ Home care/support services required ▶ ☐ Periodically ☐ Permanently

☐ Specialized services required to accommodate functional impairments

Please specify

## 5. OTHER COMMENTS RELATED TO RESETTLEMENT NEEDS

| Date (YYYY-MM-DD) | Place and PP# | Physician name | Physician signature |
|---|---|---|---|
| | | | |