



RESETTLEMENT NEEDS ASSESSMENT FORM

Family name:		UCI:
First name:		IME no.
Date of birth (YYYY-MM-DD)	<input type="checkbox"/> Male	<input type="checkbox"/> Female
There are no special travel requirements or settlement issues. <input type="checkbox"/>		

1. FUNCTIONAL ASSESSMENT

Yes	No		<input type="checkbox"/> Partial	<input type="checkbox"/> Complete	
<input type="checkbox"/>	<input type="checkbox"/>	Hearing impairment	<input type="checkbox"/> Partial	<input type="checkbox"/> Complete	
<input type="checkbox"/>	<input type="checkbox"/>	Vision impairment	<input type="checkbox"/> Partial	<input type="checkbox"/> Complete	
<input type="checkbox"/>	<input type="checkbox"/>	Speech impairment	<input type="checkbox"/> Partial	<input type="checkbox"/> Complete	
<input type="checkbox"/>	<input type="checkbox"/>	Cognitive impairment	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/>	<input type="checkbox"/>	Mobility impairment	Current mobility aid: _____		Mobility aid required: _____
<input type="checkbox"/>	<input type="checkbox"/>	Other impairment (list below and describe if possible: Example - feeding due to dental condition)			
Details					
Activities of daily living			<input type="checkbox"/> Independent	<input type="checkbox"/> Partial care	<input type="checkbox"/> Total care
Details					

2. SPECIAL TRAVEL REQUIREMENTS

<input type="checkbox"/> None	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Stretcher	<input type="checkbox"/> Medical escort required	<input type="checkbox"/> Other
Details				

3. POST-ARRIVAL SERVICES REQUIRED

<input type="checkbox"/> No services required	<input type="checkbox"/> Consultation with a health care professional required		<input type="checkbox"/> Urgent (72 hrs)	<input type="checkbox"/> Within ___ weeks	<input type="checkbox"/> As required
			<input type="checkbox"/> Specialized services	<input type="checkbox"/> Long term services	
Details					

4. HOUSING AND DAILY ACTIVITIES / ASSISTANCE REQUIREMENTS

<input type="checkbox"/> Fully independent, no assistance required	<input type="checkbox"/> Wheelchair access required		<input type="checkbox"/> Periodically	<input type="checkbox"/> Permanently	
<input type="checkbox"/> Home care/support services required			<input type="checkbox"/> Specialized services required to accommodate functional impairments		
Please specify					

5. OTHER COMMENTS RELATED TO RESETTLEMENT NEEDS

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