CUSTOMER INQUIRY CONTACT SHEET

Contacted by: Phone Email Other _____ **Date:** _____

Name of Caller: _____ **Referral Source:** _____

Phone Home: _____ Work: _____ Cell: _____

Address: _____ City: _____ Zip/PC: _____

Name of person requiring service: _____ **Age:** _____ Weight: _____

Relationship: Spouse Parent Grandparent Other □□□□□□□□□□□□□□□□□□□□ **Veteran or Spouse:** Yes No

Address: _____ City: _____ Postal Code: _____

Q: Current Client Situation:

_____

_____

Q: Details of Anticipated Need for Service:

_____

_____

Sitter/Companion	Yes • No •	Lifts/Transfers	Yes • No •
House Cleaning	Yes • No •	Transportation	Yes • No •
Cooking Meals	Yes • No •	Medications	Yes • No •
Laundry	Yes • No •	Foot Care	Yes • No •
Dressing	Yes • No •	Palliative Care	Yes • No •
Bathing	Yes • No •	Other: _____	Yes • No •
Using the Bathroom	Yes • No •	Other: _____	Yes • No •

Q: Are there any problems with: Hearing: Yes • No • Vision: Yes • No • Speech: Yes • No •

Q: Is there family support nearby? Close • Distant • None • Note: _____

Q: Is care currently being provided? Family • Friends • Provincial HC • Insurance • Private • VAC •

Details of current care: _____

Q: Is there any difficulty in movement or getting around the house?

No difficulty • Assistance required • Wheelchair • Bedridden • Other _____

Q: Service Required? Immediately • Couple Weeks • Month • Unsure • Other _____

Q: How long will service be required? _____

NOTES:

_____

_____

_____

Result of the call: Consultation: Date: _____ Time: _____ Place: _____

Nursing Assessment: • _____

General Assessment: •

- Mail Info Package Date Sent _____
- Phone Follow-up Call Date _____
- Phone Follow-up Call Date _____
- Phone Follow-up Call Date _____
- Will Call Back When _____
- Not Interested Why _____

FOLLOW UP NOTES:

QUOTATION DETAILS: