AWAC
Association Advocating for Women and Community

Hospital & Community Care Navigator Program
Client Intake & Initial Assessment

Client Information

To Be Completed with Social Worker or Referring Agency

_____ _____
Client Name: **Date of Birth:**

_____
Where is intake being completed? (if in hospital, include unit and room number):

_____
When is the expected discharge date (if in hospital):

What applications, referrals, etc have already been completed with the client?

_____

_____

_____

To Be Completed With Client

Do you identify as Indigenous? ☐ Yes ☐ No **Band:** _____ **Do you have status?** ☐ Yes ☐ No

PHN (if available): _____

Do you have a phone? ☐ Yes ☐ No

Phone Number (if available): _____ **Emergency Contact (if available):** _____

Housing Situation

Current living situation:
☐ Unsheltered / outdoors
☐ Shelter
☐ Couch surfing
☐ Temporary housing
☐ Supportive housing
☐ Unknown

Where do you usually stay? _____

How long have you been without stable housing? _____

Have you ever stayed in a shelter? _____

Are you currently restricted from all the shelters in PG? _____

Health Care Access

Do you have a family doctor or clinic? ☐ Yes ☐ No ☐ Unsure

Clinic name (if known): _____

Do you have any upcoming medical appointments? ☐ Yes ☐ No

If yes what date(s) and where: _____

_____

Health Concerns (self reported)

☐ Chronic medical conditions ☐ Recent hospital visits
☐ Mental health concerns ☐ Mobility challenges
☐ Substance use concerns ☐ Other: _____

Notes: _____

_____

Support Needs

What would help you most right now?

☐ Housing support ☐ Income assistance
☐ Medical care connection ☐ Transportation to appointments
☐ Addiction / recovery support ☐ Medication support
☐ Mental health support ☐ Outreach support
☐ ID replacement

Other: _____

Income (Optional)

What is your income source?: _____

What is your monthly income?: _____

Risk & Safety Considerations

☐ Frequent hospital use ☐ Untreated medical condition
☐ Risk of overdose ☐ Mobility limitations
☐ No safe place to stay

Notes: _____

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Immediate Action Plan

Navigator actions to be taken:

☐ Primary care connection
☐ Housing referral
☐ Recovery program referral
☐ Mental health referral
☐ Medication support
☐ Outreach follow-up

Notes: _____

_____

_____

Follow-Up Plan

_____
Next Contact Date:

_____
Location:

_____
Navigator Name:

_____
Navigator Signature:

_____
Date: