Centre intégré
de santé
et de services sociaux
de Laval

Québec

**Last name (birth name):**_____ **First name:** _____

**Date of birth: Yr. /:**_____ **M/:**_____ **D/:**_____

**Health insurance number**: _____ _____ _____ **Expiry**_____

**Address:** _____

**Postal code:** _____**Phone number :(**____**)** _____

# PRISMA-7 QUESTIONNAIRE ❖

This Prisma-7 questionnaire will allow to know if you have any needs related to your health in general. If this is the case, you will soon receive a call from your CLSC.

| **QUESTIONS** | **YES** | **NO** |
|---|---|---|
| 1. Are you 85 years old or older? | ☐ | ☐ |
| 2. Male? | ☐ | ☐ |
| 3. In general, do you have any health problems that require you to limit your activities? | ☐ | ☐ |
| 4. Do you need someone to help you on a regular basis? | ☐ | ☐ |
| 5. In general, do you have any health problems that require you to stay at home? | ☐ | ☐ |
| 6. In case of need, can you count on someone close to you? | ☐ | ☐ |
| 7. Do you regularly use a cane, a walker or a wheelchair to move about? | ☐ | ☐ |
| **Number of Yes and No** | | |

❖ **Version:** November 2016 **Authors:** Rejean Hébert, Michel Raîche and Marie-France Dubois. Property of the Centre d'expertise en santé de Sherbrooke. info@expertise-santé.com

## ADDITIONNAL QUESTIONS

| | | |
|---|---|---|
| 1. Have you fallen during the past 12 months? If Yes, How many times? _____ | ☐ | ☐ |
| 2. During the past 12 months have you lost unintentionally 10 pounds or more? | ☐ | ☐ |

❑ I agree that my answers and my contact information may be disclosed to the **Integrated Health and Social Services of Laval*** which will contact me only if required.

❑ I authorize the **Integrated Health and Social Services of Laval** to do a follow-up with my treating physician or any other professional involved in my situation.

_____ _____ _____

Signature of the person or a representative Date Telephone number

_____

Title or relationship

## SECTION RESERVED FOR THE REFERRER

Referrer's last name: _____ Referrer's first name: _____

Organization (if relevant): _____ Title (if relevant): _____

Address: _____Postal code: _____Phone number: _____

Contact person:_____Relationship:_____

Address and tel. if different from the referrer _____

Spoken language: ☐ French ☐ English ☐ Other _____

Comments: _____

_____

_____



* The completed form must be sent by fax at : 450 967-1803