

# PHYSICIAN ASSESSMENT

Amica On The Avenue  
416-483-9900

I authorize Dr. \_\_\_\_\_ to complete this form to the best of his/ her knowledge according to the information in my medical records.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

Given Name: \_\_\_\_\_ Surname: \_\_\_\_\_

DOB: \_\_\_\_\_ PHN: \_\_\_\_\_

Does your patient have a current DNR directive? Yes  No

<b>Communicable Disease History:</b>	<b>Hepatitis</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	<b>C-diff</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
<b>MRSA+</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	<b>VRE+</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	<b>ESBL+</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
<b>Shingles</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	<b>HIV</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	Other: _____

**Immunization Status:** *Chest X-Ray report is required for all clients >65 yrs within 14 days of move-in*

**Tetanus:** Yes  No  Date: \_\_\_\_\_ **Influenza:** Yes  No  Date: \_\_\_\_\_ **Pneumovax:** Yes  No  Date: \_\_\_\_\_

**Covid-19 Vaccine:** Yes  No  Date Dose1: \_\_\_\_\_ Date Dose2: \_\_\_\_\_ Other: \_\_\_\_\_  
(Include childhood immunization if known)

**Influenza Season Preparedness:**

Authorize an Influenza Virus Vaccine 0.5 ml intramuscular injection once yearly- indefinitely (until otherwise specified)

**In case of influenza outbreak, our Team will be requested by Public Health to administer an antiviral (Tamiflu) regimen (Treatment/prophylactic). The following information will determine the dosage which will be calculated by the pharmacist based on commonly accepted Public Health guidelines (choose one):**

\* Resident Serum Creatinine (within last yr) \_\_\_\_\_ Date Obtained: \_\_\_\_\_ If >1 yr; enclose lab work req. for annual creatinine level

Do NOT renal dose adjust

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FUNCTIONAL ABILITY:**

Falls within last month: Yes  No  If 'Yes'- Referral OT/PT made? Yes  No

**SENSORY IMPAIRMENTS:** Hearing: Yes  No  Vision: Yes  No

If 'Yes' please explain:

<b>COGNITIVE FUNCTION:</b>		
Memory loss: Yes <input type="checkbox"/> No <input type="checkbox"/>	Behavioural Issues: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Risk for Flight or Wandering: Yes <input type="checkbox"/> No <input type="checkbox"/>	History/Risk for Physical/Verbal Aggression: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Mental health illness: Yes <input type="checkbox"/> No <input type="checkbox"/>	Risk for Self-Harm or Harm to Others: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Capable to consent to move-in: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Is there an M.M.S.E./MoCa score on file? Yes <input type="checkbox"/> No <input type="checkbox"/>	Score: /30	Date:
If responded 'YES' to any of the above, please provide additional information/documentation:		

<b>MEDICAL HISTORY:</b>	
History of Drug Addiction or Alcoholism? Yes <input type="checkbox"/> No <input type="checkbox"/>	Smoker: Yes <input type="checkbox"/> No <input type="checkbox"/>
Primary Diagnosis: Please list	Hospitalization/Surgical History: Please list reason/year
1. _____ 4. _____	1. _____ 4. _____
2. _____ 5. _____	2. _____ 5. _____
3. _____ 6. _____	3. _____ 6. _____

<b>MEDICATION:</b> PLEASE ATTACH LIST	Able to Self-Medicare Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>If not able to self-medicate, please provide list with signed physician medication orders that will enable us to administer your patient's medications.</b>	
<b>Allergies (drug or other):</b>	
Special dietary requirements:	Swallowing Disorder: Yes <input type="checkbox"/> No <input type="checkbox"/>
Consults/referrals within the last 6 months(Geriatrician, Mental Health, OT,PT, Home Nursing Care, Community/Agency Home Support, etc):	

<b>SUPPORTIVE DOCUMENTATION REQUIRED AS MANDATED BY THE RHA:</b>	
<input type="checkbox"/> Chest X-Ray for residents >65 or TST for residents <65 <input type="checkbox"/> Medication List	
<b>PHYSICIAN'S NAME:</b>	<b>PHYSICIAN'S SIGNATURE:</b>
Do you intend to continue as the primary physician once this patient moves to Amica™? : Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>PHYSICIAN'S ADDRESS, PHONE , FAX OR STAMP</b>	