

PHYSICIAN ASSESSMENT

Amica Whitby

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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

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

COGNITIVE FUNCTION:		
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:		

MEDICAL HISTORY:	
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. _____

MEDICATION: PLEASE ATTACH LIST	Able to Self-Medicate Yes <input type="checkbox"/> No <input type="checkbox"/>
If not able to self-medicate, please provide list with signed physician medication orders that will enable us to administer your patient's medications.	
Allergies (drug or other):	
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):	

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