# PHYSICIAN ASSESSMENT

## Amica Swan Lake

Phone 905-201-6058 • Fax 905-201-6059

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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: _____

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Given Name: _____ Surname: _____

DOB: _____ PHN: _____

Does your patient have a current DNR directive? Yes ☐ No ☐

Communicable Disease **History:**

**MRSA+** Yes ☐ No ☐ Unknown ☐

**Shingles** Yes ☐ No ☐ Unknown ☐

**Hepatitis** Yes ☐ No ☐ Unknown ☐

**VRE+** Yes ☐ No ☐ Unknown ☐

**HIV** Yes ☐ No ☐ Unknown ☐

**C-diff** Yes ☐ No ☐ Unknown ☐

**ESBL+** Yes ☐ No ☐ Unknown ☐

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: | | |

AMICA

SENIOR LIFESTYLES

| **COGNITIVE FUNCTION:** | | |
|---|---|---|
| Memory loss: Yes ☐ No ☐ | Behavioural Issues: Yes ☐ No ☐ | |
| **Risk for Flight or Wandering:** Yes ☐ No ☐ | **History/Risk for Physical/Verbal Aggression:** Yes ☐ No ☐ | |
| **Mental health illness:** Yes ☐ No ☐ | **Risk for Self-Harm or Harm to Others:** Yes ☐ No ☐ | |
| **Capable to consent to move-in:** Yes ☐ No ☐ | | |
| Is there an M.M.S.E./MoCa score on file? Yes ☐ No ☐ | 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 ☐ No ☐ | Smoker: Yes ☐ No ☐ |
| Primary Diagnosis: Please list<br>1. _____ 4. _____<br>2. _____ 5. _____<br>3. _____ 6. _____ | Hospitalization/Surgical History: Please list reason/year<br>1. _____ 4. _____<br>2. _____ 5. _____<br>3. _____ 6. _____ |

| **MEDICATION:** PLEASE ATTACH LIST | Able to Self-Medicate Yes ☐ No ☐ |
|---|---|
| **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 ☐ No ☐ |
| 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:**

☐ Chest X-Ray for residents >65 or TST for residents <65 ☐ Medication List

| **PHYSICIAN'S NAME:** | **PHYSICIAN'S SIGNATURE:** |
|---|---|
| Do you intend to continue as the primary physician once this patient moves to Amica™? : Yes ☐ No ☐ | |
| **PHYSICIAN'S ADDRESS, PHONE , FAX OR STAMP** | |