PHYSICIAN ASSESSMENT

Amica Bayview Gardens

Phone 647-286-7935 • Fax 416-730-9277

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:**

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 1. _____ 4. _____ 2. _____ 5. _____ 3. _____ 6. _____	Hospitalization/Surgical History: Please list reason/year 1. _____ 4. _____ 2. _____ 5. _____ 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	