

PHYSICIAN ASSESSMENT

Amica Westboro Park

Phone 613-728-9274 • Fax 613-728-9276

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: | | |

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|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| 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. _____ |

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| 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): | |

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| 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 | |