

Massawippi Christian Retirement Homes
Medical Form

To be completed by the Applicant and their medical doctor

This section to be completed by the Applicant (or a family member):

Name of Applicant:		
Last name	First name	Last name at birth
Date of Birth:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Mobility	<input type="checkbox"/> Independent <input type="checkbox"/> Assistance required <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair	
Feeding	<input type="checkbox"/> Independent <input type="checkbox"/> Assistance required Comments:	
Bathing	<input type="checkbox"/> Independent <input type="checkbox"/> Assistance required	
Sleeping	<input type="checkbox"/> Sleeps Well <input type="checkbox"/> Sleeps Poorly <input type="checkbox"/> Restless <input type="checkbox"/> Sedatives prescribed	
Dressing	<input type="checkbox"/> Independent <input type="checkbox"/> Assistance required Able to dress him/herself by 7:30 AM <input type="checkbox"/> Yes <input type="checkbox"/> No	
Bladder – Day	<input type="checkbox"/> Continent <input type="checkbox"/> Incontinent Comments:	
Bladder – Night	<input type="checkbox"/> Continent <input type="checkbox"/> Incontinent Comments:	
Bowels	<input type="checkbox"/> Continent <input type="checkbox"/> Incontinent Comments:	
Name of Applicant's Medical Doctor	Doctor's Name: Address: City: Telephone:	

This section to be completed by your Medical Doctor:

The person identified on page one has applied for residency at

Grace Christian Home Connaught Home

Please complete this medical form and return it either to the Applicant or to the Home in order that the Applicant may be considered for residency.

Review of Applicant's Assessment	Are the answers given on page one by the applicant consistent with your knowledge of this patient? <input type="checkbox"/> YES <input type="checkbox"/> NO
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Medical History

Active / Pertinent Diagnosis: Chronic Diagnosis:	
Hospitalizations: Recent Remote	
Medications and treatments: <input type="checkbox"/> List Attached Inhalers, Eye Drops, Others:	Oral:

Most Recent Flu shot date:	
Pneumoccal Vaccination date:	
Tetanus date:	
Awaiting:	<input type="checkbox"/> Evaluation <input type="checkbox"/> Investigation <input type="checkbox"/> Treatment
Allergies: <input type="checkbox"/> Medication <input type="checkbox"/> Food <input type="checkbox"/> Environment / Contact	Specify:
Special Diet:	
Vision:	<input type="checkbox"/> Normal <input type="checkbox"/> Impaired: <input type="checkbox"/> Right / <input type="checkbox"/> Left <input type="checkbox"/> Glasses
Hearing:	<input type="checkbox"/> Normal <input type="checkbox"/> Impaired: <input type="checkbox"/> Right / <input type="checkbox"/> Left <input type="checkbox"/> Hearing Aids: <input type="checkbox"/> Right / <input type="checkbox"/> Left
Skin Integrity	
Communicable diseases/infections	

Mental Status

Folstein _____ Date _____

Cognitive Assessment <input type="checkbox"/> Not impaired <input type="checkbox"/> Impaired (as indicated)	Level of Consciousness <input type="checkbox"/> Alert <input type="checkbox"/> Drowsy <input type="checkbox"/> Stuporous <input type="checkbox"/> Comatose	Memory Loss <input type="checkbox"/> Occasional forgetfulness <input type="checkbox"/> Short Term <input type="checkbox"/> Long Term	Disoriented <input type="checkbox"/> To Time <input type="checkbox"/> To Place <input type="checkbox"/> To Person (self) <input type="checkbox"/> To Person (others) <input type="checkbox"/> To own environment <input type="checkbox"/> To other environment	Attention <input type="checkbox"/> Inattentive <input type="checkbox"/> Incomplete thoughts <input type="checkbox"/> Wanders off topic <input type="checkbox"/> Decreased concentration
	Affect / Mood <input type="checkbox"/> Sad <input type="checkbox"/> Flat <input type="checkbox"/> Anxious <input type="checkbox"/> Euphoric <input type="checkbox"/> Loss of Interest <input type="checkbox"/> Guilt <input type="checkbox"/> Grieving <input type="checkbox"/> Other:	Judgment <input type="checkbox"/> Unrealistic planning <input type="checkbox"/> Decreased ability to problem-solve <input type="checkbox"/> Inability to problem solve <input type="checkbox"/> Inability to make decisions <input type="checkbox"/> Lacks insight <input type="checkbox"/> Impulsive <input type="checkbox"/> Unconventional elimination	Altered Thought Processes <input type="checkbox"/> Suspicious / paranoid <input type="checkbox"/> Social withdrawal <input type="checkbox"/> Frightened / phobia <input type="checkbox"/> False beliefs / perceptions <input type="checkbox"/> Delusions <input type="checkbox"/> Hallucinations: visual <input type="checkbox"/> Hallucinations: auditory	Comments:

Behavioural Assessment <input type="checkbox"/> Not impaired <input type="checkbox"/> Impaired (as indicated)	Wandering <input type="checkbox"/> Wanders inside / stays in immediate environment <input type="checkbox"/> Returns to own room without help <input type="checkbox"/> Unable to locate own room <input type="checkbox"/> Wanders into corridors <input type="checkbox"/> Wanders into others' room <input type="checkbox"/> Wanders outside <input type="checkbox"/> Will leave immediate environment if not prevented Behaviour provoked by: <input type="checkbox"/> Stress <input type="checkbox"/> Changes		Aggression / Anger <input type="checkbox"/> Present <input type="checkbox"/> Past history Verbal: <input type="checkbox"/> Predictable <input type="checkbox"/> Unpredictable <input type="checkbox"/> Occasional <input type="checkbox"/> Frequent Physical: <input type="checkbox"/> Predictable <input type="checkbox"/> Unpredictable <input type="checkbox"/> Occasional <input type="checkbox"/> Frequent		Agitation with: <input type="checkbox"/> Major changes / occasional <input type="checkbox"/> Minor changes / frequent <input type="checkbox"/> Without stimulus / constant <input type="checkbox"/> Restless <input type="checkbox"/> Cries out <input type="checkbox"/> Paces <input type="checkbox"/> Chatters <input type="checkbox"/> Constant repetitive noise/ moaning
	Suspiciousness <input type="checkbox"/> Foods / medications <input type="checkbox"/> People / objects <input type="checkbox"/> Causes no disruption <input type="checkbox"/> Disrupts daily routine <input type="checkbox"/> Occasional <input type="checkbox"/> Frequent	Hoarding / Rummaging <input type="checkbox"/> Foods / medications <input type="checkbox"/> Picks up objects <input type="checkbox"/> Searches others' belongings <input type="checkbox"/> Loses and misplaces things <input type="checkbox"/> Collects /accumulates/ clutters	Exit Seeking <input type="checkbox"/> Time: <input type="checkbox"/> Freq: <input type="checkbox"/> Resistive to redirection <input type="checkbox"/> Reason:		Attention seeking <input type="checkbox"/> Physical / psychological complaints <input type="checkbox"/> Occasional <input type="checkbox"/> Frequent <input type="checkbox"/> Constant <input type="checkbox"/> Specify:
	High Risk Behaviours <input type="checkbox"/> Fire setting <input type="checkbox"/> Eats foreign substances <input type="checkbox"/> Danger to Self <input type="checkbox"/> Danger to Others <input type="checkbox"/> Other: Sexuality <input type="checkbox"/> Disinhibited touching <input type="checkbox"/> Disinhibited remarks / gestures <input type="checkbox"/> Exposure <input type="checkbox"/> Frequency:	Smoking <input type="checkbox"/> Occasional <input type="checkbox"/> Frequent <input type="checkbox"/> Unsafe <input type="checkbox"/> Planning to quit <input type="checkbox"/> Date quit: Alcohol / drug use <input type="checkbox"/> Occasional <input type="checkbox"/> Frequent <input type="checkbox"/> Behaviour problems with use <input type="checkbox"/> No problems noted	Resistance to Treatment <input type="checkbox"/> Occasional <input type="checkbox"/> Frequent <input type="checkbox"/> Complies if persuaded <input type="checkbox"/> Refuses care & can't be persuaded <input type="checkbox"/> Frequency: Suicidal <input type="checkbox"/> Thoughts <input type="checkbox"/> Prior history <input type="checkbox"/> Indicates has plans <input type="checkbox"/> Verbalizes threat <input type="checkbox"/> Attempts in past		Noted behaviour occurs: <input type="checkbox"/> Days <input type="checkbox"/> Evenings <input type="checkbox"/> Nights Behaviour controlled by: <input type="checkbox"/> Medication <input type="checkbox"/> Approach
Additional Comments:					

Doctor's Recommendation:

- Autonomous
 Semi-Autonomous
 Infirmery Care
 May soon require Infirmery care

Signature of Physician

Date

Grace Christian Home 1501, rue Campbell, Sherbrooke, QC J1M 0C1 (819) 569-0546
 Connaught Home 77 rue Main, North Hatley, QC J0B 2C0 (819) 842-2164