Український Дім для Сеньйорів ім. свв. Петра і Павла
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WS

MEDICAL ASSESSMENT FORM -- PRE - ADMISSION

****CONFIDENTIAL WHEN COMPLETED****

Name of Applicant

(Surname) (Given Names)

Social Insurance Number

Date of Birth | Sex | Age | Height | Weight | ☐ Smoker ☐ Non Smoker | Health Card Number

Section A - Assessment of General Care Needs

1. Skin

Check each question	Yes	No
a) Ulcers		
b) Rash		
c) Bruises		
d) Abrasions		
e) Other abnormalities		

explain:

2. Mental State

Check each question	Yes	No
a) Occasional brief periods of recent memory loss and confusion		
b) Marked confusion and disorientation with brief periods of being alert		
c) Persistent confusion and disorientation		
d) Organic brain syndrome and/or senile dementia		
e) Developmental Disability		

3. Behaviour

Check each question	Yes	No
a) Quiet and co-operative		
b) Unco-operative		
c) Abnormally talkative		
d) Suspicious		
e) Noisy		
f) Quarrelsome		
g) Requires restraint		
h) Verbal outbursts		
i) Violent outbursts		
j) History of aggression		
k) History of assaults		
l) History of threats		

4. Functional Activity

Check each question	Yes	No
a) Bladder control		
full control		
incontinent		
comments:		
b) Bowel control		
full control		
incontinent		
comments:		
c) Able to speak normally		
d) Registered Blind Person		

4. Functional Activity (cont'd)

	Yes	No
e) Able to read		
f) Able to hear speech at normal level		
g) Able to wash face and hands		
h) Able to bathe and shower self		
i) Able to use toilet facilities		

5. Use of limbs

Check each question ☐ Left handed ☐ Right handed

Arms and hands:	L	R
a) Normal use		
b) Impaired use		
c) No use		
d) Amputation		

Lower Limbs:	L	R
a) Normal use		
b) Impaired use		
c) No use		
d) Amputation		

6. Feeding

Check each question	Yes	No
a) Feeds self		
b) Needs supervision		
c) Needs assistance		
d) Needs feeding		
e) Special diet(s)		

specify:

7. Dressing

Check each question	Yes	No
a) Independent		
b) Needs supervision or assistance		
c) Needs to be dressed		

8. Mobility

Check each question	Yes	No
a) Able to walk without help		
b) Requires walking aids (specify)		
cane		
walker		
wheelchair		
* self propelled		
* assisted		
* motorized		
c) Requires assistance		
i) to walk		
ii) to lift in and out of chair		
iii) to move wheelchair		
d) Can get in or out of bed		
e) Needs some help to get in and out of bed		
f) Needs lifting in and outof bed		
g) Needs to be turned in bed		
h) Bedridden		

Overall care level:	light		medium		heavy		

Section B - Attending Physician's Report

	Yes	No
1. Injections		
*subcutaneous		
*intramuscular		
2. Sterile dressings		
3. Tube feeding or intubation		

If "Yes", please specify: _____

_____

	Yes	No
4. Irrigations		
5. Indwelling catheter		
6. Lab Services		
*Haematology		
*Blood Chem.		
7. INR		

	Yes	No
8. Rehabilitation Services		
*Physiotherapy		
*Occupational Therapy		
*Speech Therapy		
*Vocational Assess.		

Other: *(specify)* _____

_____

_____

_____

1. Medical History:

2. Slips and Falls History:

3. Present Condition:

4. Present Medication with Dosage: (attach)

5. Allergies and Drug Sensitivities:

6. Diagnoses: List in spaces A, B, C, D, E, F in order of importance, the conditions that make care or treatment necessary.

	Duration		
	Wks.	Mos.	Yrs.
A			
B			
C			
D			
E			
F			

For each condition indicate your assessment in each vertical line in the Prognosis:

	A	B	C	D	E	F
7. Prognosis:	↓	↓	↓	↓	↓	↓
a) Little effect on life span	☐	☐	☐	☐	☐	☐
b) Improvement in 3 months	☐	☐	☐	☐	☐	☐
c) Some deterioration in 3 months	☐	☐	☐	☐	☐	☐
d) Probably fatal in 3 months	☐	☐	☐	☐	☐	☐
8. Rehabilitation Potential:						
a) Independent living	☐	☐	☐	☐	☐	☐
b) Moderate to self-care level	☐	☐	☐	☐	☐	☐
c) Limited	☐	☐	☐	☐	☐	☐
d) None	☐	☐	☐	☐	☐	☐
9. Present State of Disease:						
a) Stable	☐	☐	☐	☐	☐	☐
b) Mildly active	☐	☐	☐	☐	☐	☐
c) Active	☐	☐	☐	☐	☐	☐
10. Purpose of Medical Care						
a) Maintenance	☐	☐	☐	☐	☐	☐
b) Evaluation and treatment	☐	☐	☐	☐	☐	☐
c) Rehabilitation	☐	☐	☐	☐	☐	☐
d) Palliative therapy	☐	☐	☐	☐	☐	☐

10. If stay is to be temporary, expected duration:
(7 days minimum is required)

☐ Weeks

☐ Months

Section C - Infectious Diseases History

Disease	Past History Yes	Past History No	Date(s) Administered 1	Date(s) Administered 2	Date(s) Administered 3	Current Assessment / Follow Up
ESBL	☐	☐				
VRE	☐	☐				
MRSA	☐	☐				
C DIFFICILE	☐	☐				
TB Screening / Chest Xray **(MANDATORY - results attached)**	☐	☐				
COVID-19 TEST **(MANDATORY - results attached)**	☐	☐				

Section D - Vaccinations / Immunizations

	Date Administered
Shingles	
Hep B & C	
Pneumococcal	
Seasonal Influenza	
Tetanus	

Comments:

What is your professional relationship with the applicant	Yes	No	
a) Family doctor	☐	☐	
b) Specialist	☐	☐	
c) Emergency Hospital Doctor	☐	☐	(what discipline?)
d) Surgeon	☐	☐	(what discipline?)

Prepared by:

Name of Doctor: _____ (please print)

Address: _____

_____

_____

Telephone: _____

Facsimile: _____

_____ Date of patient's last visit

_____ Signature of Physician

_____ Date

Certification: The statements herein contained are correct to the best of my professional knowledge, and accurately reflect the present care needs of the applicant.

THIS FORM MUST BE CURRENT 30 DAYS PRIOR TO ADMISSION DATE.