Physician's Statement.

Applicant's Name: _____

Date: _____

Completed By: _____

Telephone: _____

Suite # : _____

Please return the Physician's Statement to:

Wellness Manager: Fax : (905) 492-5288

V!VA Pickering Retirement Community
1880 Glengrove Road, Pickering, ON, L1V 0C6
(905) 831-2088 | vivalife..ca

V!VA Retirement Communities™
PICKERING

Version Date: November 30, 2024

V!VA Retirement Communities Physician's Statement

APPLICANT DETAILS

Given Name _____ Surname _____

Contact Name (if other than Applicant) _____

Contact Phone # (Home) _____

APPLICANT ADDRESS

Number _____ Street _____ Apt. _____

City/Town _____ Province _____ Postal Code_____

Telephone Number _____

Health Card # _____ Birth Date _____

PHYSICAL ASSESSMENT

A Chest x-ray is requested because the TB symptom screening was not passed. ☐ Yes ☐ No

due to: _____

Creatinine Level (for antiviral administration in the event of outbreak) Date _____ Result _____

Tuberculosis skin test: Copy of Results Attached ☐ Yes ☐ No ☐ N/A

Height: _____ Weight: _____ BP: _____

Allergies: Food _____ Drug _____ Environmental _____

Flu Vaccine Last Date Done: _____ Tetanus_____ RSV _____

Shingles Vaccine _____ Pneuomovax/Prevnar Vaccine: _____

Covid #1_____ # 2_____ How many boosters? _____

C-DiFF/V.R.E./M.R.S.A. ☐ Yes ☐ No Other infectious disease: _____

Has the applicant been hospitalized during the past 6 month? ☐ Yes ☐ No

Special Dietary Requirements: _____

Current Diagnosis: _____

_____

_____

Previous Illness: _____

_____

Previous Surgery: _____

_____

Smoker: ☐ Yes ☐ No Substance Abuse ☐ Yes ☐ No

Alcohol Use: ☐ Yes ☐ No

Frequency: _____ Describe: _____

MEDICATIONS

May administer own medications: ☐ Yes ☐ No

Nurse to medicate: ☐ Yes ☐ No

If nurse to medicate, include new prescriptions for all medications, vitamins, supplements, creams, and injections.

Current Medications: _____

_____

_____

_____

_____

FUNCTIONAL ASSESSMENT

Provide any consult notes from a geriatric specialist/GAIN clinic/BSO.

MENTAL STATUS

☐ Alert/Lucid ☐ Depressed ☐ Previous Psychiatric History ☐ Dementia

☐ Forgetful ☐ Suicidal Tendencies ☐ Exit Seeking MMSE/MOCA Score: _____

☐ Other behaviours: _____

Please Comment: _____

_____

_____

Senses	Normal	Impaired	Deficit
Hearing			
Vision			
Speech			

AMBULATION

Normal: ☐ Yes ☐ No Requires Assistance: ☐ Yes ☐ No

Assistive Device(s): _____

History of Falls: ☐ Yes ☐ No Please comment: _____

ACTIVITIES OF DAILY LIVING

A.D.L..	Independent	Requires Assistance	Comments: _____
Eating	☐	☐	_____
Bathing	☐	☐	_____
Dressing	☐	☐	_____

ELIMINATION	Normal	Incontinent	Comments: _____
Bowel	☐	☐	_____
Bladder	☐	☐	_____

PHYSICIAN INFORMATION

How long has applicant been under Family Physician's care? _____

Physician's Address

_____
Number Street Suite

_____
City/Town Province Postal Code

_____
Telephone Number Fax No. Email

Physician's signature _____ Date: _____

Physician's name: _____
(please print name)

Please attach: ☐ Tamiflu Orders

☐ Rx for Medications (if nurse to medicate)

☐ Chest X-Ray (if applicable)