

Physician's Statement.

Applicant's Name: _____

Date: _____

Completed By: _____

Telephone: _____

Suite # : _____

Please return the Physician's Statement to:

Wellness Manager: Fax : (613) 257-2662

Waterside Retirement Community
105 McNeely Avenue, Carleton Place, ON, K7C 0B6
(613) 253-2010 | vivalife.ca



VIVA 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 _____ Pneumovax/Prevnar Vaccine: _____

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

C-DIFF/V.RE./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

ADL.	<u>Independent</u>	<u>Requires Assistance</u>	Comments: _____
Eating	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	_____

ELIMINATION	<u>Normal</u>	<u>Incontinent</u>	Comments: _____
Bowel	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder	<input type="checkbox"/>	<input type="checkbox"/>	_____

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)