

Physician's Statement.

Applicant's Name: _____

Date: _____

Completed By: _____

Telephone: _____

Suite # : _____

Please return the Physician's Statement to:

Wellness Manager: Fax : (613) 823-0201

VIVA Barrhaven Retirement Community

275 Tartan Dr, Nepean, ON K2J 6A9

(613) 823-0220 | vivalife.ca



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 _____ Pneumovax/Prevnar Vaccine: _____

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

C-DiFF/V.R.E./MRSA. ☐ 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: _____
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Eating	☐	☐	_____
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Bathing	☐	☐	_____
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Dressing	☐	☐	_____
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ELIMINATION	<u>Normal</u>	<u>Incontinent</u>	Comments: _____
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Bowel	☐	☐	_____
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Bladder	☐	☐	_____
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PHYSICIAN INFORMATION

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

Physician's Address

Number	Street	Suite
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City/Town	Province	Postal Code
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Telephone Number	Fax No.	Email
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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)