Physician's Statement.

Applicant's Name: _____

Date: _____

Completed By: _____

Telephone: _____

Suite # : _____

Please return the Physician's Statement to:

Wellness Manager: Fax : (905) 997-1657

V!VA Mississauga Retirement Community
5575 Bonnie Street, Mississauga, ON L5M 0N8
(905) 566-4500 | vivalife..ca

V!VA Retirement Communities™
MISSISSAUGA

Version Date: October 30 2024

V!VA Retirement Communities Physician's Statement

APPLICANT DETAILS

Given Name _____ Initial _____ Surname _____

Contact Name (if other than Applicant) _____

Contact Phone # (Home) _____ (Business) _____

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 sympton screening was not passed. ☐ Yes ☐ No

due to: _____

Creatinine Level (for anti-viral calculation, if requested for an outbreak) Date _____ Result _____

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

Height: _____ Weight: _____ Diet: _____ BP:_____

Allergies: Food _____ Drug _____ Environmental _____

Flu/Vaccine/Last Date Done:_____ Tetanus/RSV/Shingles_____

Pneumomac Vaccine Date: _____ 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

Provide new RX for all medications, Vits, OTC, Creams.

Current Medications: _____

_____

_____

_____

_____

FUNCTIONAL ASSESSMENT

Provide any consult notes from a geriactic specialist/gain clinic/BSO.

MENTAL STATUS

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

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

☐ Other behaviours: _____

Please Comment: _____

_____

_____

Senses	Normal	Impaired	Deficit
Hearing			
VIsion			
Speech			

AMBULATION

Normal: ☐ Yes ☐ No Require Assistance: ☐ Yes ☐ No

Assistive Device(s): _____

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

ACITIVITIES OF DAILY LIVING

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

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

PHYSICIAN INFORMATION

Name of Family Physician: _____
(Please print name)

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)