MEDICAL REPORT FOR RESIDENCY

NAME: (MR. MRS. MS. MISS) ____

DATE OF BIRTH: _____________________________

SEX: ______ MALE _______ FEMALE

ADDRESS: ____

DATE EXAMINED: ___________________________

EXAMINING PHYSICIAN (PLEASE PRINT):________________________________

ADDRESS: ____

Note: Our accommodation is not to provide physical or medical assistance to residents. Some care is available to seniors through Home Care and Home Services. It is the responsibility of family and doctor to arrange for these services prior to residency.

PHYSICAL EXAMINATION

B.P.: ______________________ SIGHT: Good ____________ Impaired: __________

HEARING: Good ______________Impaired: _____________

MOBILITY: Mobility without help ____
Mobility with Equipment ____

IS THERE A COMMUNICATION DIFFICULTY? ______YES ______NO
IF YES EXPLAIN: ____
____

MEDICAL DIAGNOSIS: ____
____

MEDICATIONS: ______YES ______NO

ABLE TO LOOK AFTER MEDICATION? ______YES ______NO

IF NO, PLEASE REFER TO HOME CARE. ASSISTANCE REQUIRED?
_______YES _______NO
IF YES, DESCRIBE NATURE:
____

ALLERGIES, DRUG INTOLERANCE OR FOOD SENSITIVITY: _________________
____

BLADDER INCONTINENCE: _______YES _______NO
IF YES, EXPLAIN: ____
____

BOWEL INCONTINENCE: _______YES _______NO
IF YES, EXPLAIN: ____
____

DOES THE APPLICANT SHOW ANY SIGNS OF DEMENTIA? ______YES ______NO
IF YES, EXPLAIN: ____
____

DO YOU CONSIDER THIS APPLICANT TO BE SUITABLE MENTALLY AND PHYSICALLY TO ENTER A LODGE WHERE NO SPECIAL CARE, NURSING CARE, OR SPECIAL DIETS ARE AVAILABLE: ______YES _______NO

DOES THE PATIENT SUFFER FROM A COMMUNICABLE DISEASE?
_______YES _______NO
IF YES, EXPLAIN: ____
____

______________________________________ ______________________________
DOCTOR'S SIGNATURE DATE

______________________________________ ______________________________
ADDRESS PHONE NUMBER

THIS CERTIFICATE IS VALID FOR SIX MONTHS ONLY!