

Pre-Admission Physician's Statement

Required for every new resident before move-in

Dear Doctor _____

To determine whether our services are suitable to meet the medical needs of your patient, we require some basic medical information.

Residents are anticipated to be independent in their daily activities and self-ambulatory, and some may be able to self-medicate. At Emerald Retirement Residence we are able to accommodate residents who use a wheelchair; however, they are expected to be able to transfer themselves with minimal assistance. Our Health and Wellness staff are able to assist with medications, personal hygiene, bathing and dressing.

To help us meet your patient's needs, we ask for your assistance in providing an accurate medical history. We thank you in advance.

How to return this form

Email gm@emeraldresidence.ca **Fax** 905-358-2502 or send the completed form with your patient.

Please return it at least ten days before the planned move-in date. The prospective resident cannot move into Emerald Retirement Residence until this statement has been received.

SECTION 1

Completed by the resident or family

Resident Information

Given name		Initial	Surname	
Street number	Street		Apt. / Unit	
City / Town		Province	Postal code	
Telephone	Date of birth (DD / MM / YYYY)		Health card number	
Decision-making ☐ Self ☐ Power of Attorney ☐ Substitute Decision-Maker				

SECTION 2

To be completed by the physician

Physical Assessment

Resident's name	Date of birth
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IMMUNIZATIONS & INFECTION CONTROL

Tetanus immunization — date	Influenza vaccine — date last given	Pneumococcal (Pneumovax) vaccine — date
COVID-19 vaccination dates		Evidence of infectious disease
VRE / MRSA positive ☐ Yes ☐ No	Mantoux test I — date	Result
	Mantoux test II — date	Result
Date of last chest X-ray	Chest X-ray report ☐ Copy of CXR report attached — required by Emerald Retirement Residence as proof of TB-negative status	

VITALS & CLINICAL MEASURES

Allergies (drug / environmental / food)			
Height	Weight	Blood pressure	Diet
Creatinine level (for antiviral dose calculation)	Date	Current treatment / lab work	
Services in use			

FUNCTIONAL & HEALTH STATUS

Has the resident been hospitalized during the past 6 months?	☐ Yes ☐ No	
Is the resident able to self-medicate?	☐ Yes ☐ No	
History of falls?	☐ Yes ☐ No	
Bowel continence	☐ Normal ☐ Incontinent	
Bladder continence	☐ Normal ☐ Incontinent	
Diet / special dietary requirements		
Swallowing or oral health issues / concerns?	☐ Yes ☐ No	
Skin integrity — open wounds		
Consults / referrals in the last 6 months?	☐ Yes ☐ No	If yes, specify:

SECTION 3

To be completed by the physician

Medical History & Current Medications

Resident's name	Date of birth
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MEDICAL ASSESSMENT

Brief medical / surgical history Include recent health problems

CURRENT MEDICATIONS

Include dosage, frequency, route and date prescribed. If the resident's medications will be nurse-administered, prescriptions must be provided three days before move-in so that our pharmacy can fill them.

Medication	Dosage	Frequency	Route	Date prescribed

SECTION 4

*To be completed by the physician***Lifestyle, Cognition & Behaviour**

Resident's name	Date of birth
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Alcohol use?	☐ Yes ☐ No	If yes, how often:
Substance use?	☐ Yes ☐ No	If yes, how often:
Smoker?	☐ Yes ☐ No	
Memory loss?	☐ Yes ☐ No	
History of wandering / elopement?	☐ Yes ☐ No	
History of harmful behaviours (to self or others)?	☐ Yes ☐ No	
Mental health illness?	☐ Yes ☐ No	If yes, please specify:
Is there an MMSE / MoCA score on file?	☐ Yes ☐ No	Score:

SECTION 5

Physician Declaration

Physician name	Phone
Address	Fax
Will you continue as the family physician once your patient resides at Emerald Retirement Residence? ☐ Yes ☐ No	
Physician signature	Date

SECTION 6

Resident Consent

I give permission to my physician to conduct this physical examination, to complete this form and to provide all information that is pertinent to my medical history.

Signature of resident or Substitute Decision-Maker	Print name	Date
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