



Retirement Centre

MEDICAL ASSESSMENT

NAME _____

PRIMARY DIAGNOSIS			
SECONDARY DIAGNOSIS			
PREVIOUS ILLNESS/SURGERY			
PERTINENT SYMPTOMS AND PRESENT PHYSICAL FINDINGS			
PROGNOSIS <input type="checkbox"/> IMPROVE <input type="checkbox"/> REMAIN STABLE <input type="checkbox"/> DETERIORATE <input type="checkbox"/> MAINTENANCE		DIAGNOSIS DISCUSSED WITH PATIENT WITH FAMILY YES <input type="checkbox"/> No <input type="checkbox"/> YES <input type="checkbox"/> No <input type="checkbox"/>	PROGNOSIS DISCUSSED WITH PATIENT WITH FAMILY YES <input type="checkbox"/> No <input type="checkbox"/> YES <input type="checkbox"/> No <input type="checkbox"/>
MEDICATIONS			
ALLERGIES			
REQUIRES OXYGEN <input type="checkbox"/> YES <input type="checkbox"/> NO		AMOUNT	MODE
MAY ADMINISTER OWN MEDICINE <input type="checkbox"/> YES <input type="checkbox"/> NO		DIET	
SERVICE REQUESTED	ORDERS AND CONTRAINDICATIONS (TREATMENTS WILL BE TAUGHT/REDUCED UNLESS OTHERWISE INDICATED)		
<input type="checkbox"/> NURSING			
<input type="checkbox"/> SOCIAL WORK			
<input type="checkbox"/> SPEECH THERAPY			
<input type="checkbox"/> OCCUPATIONAL THERAPY			
<input type="checkbox"/> PHYSIOTHERAPY <input type="checkbox"/> OTHER			
DEGREE OF WEIGHT BEARING	<input type="checkbox"/> NONE	<input type="checkbox"/> PARTIAL	<input type="checkbox"/> FULL <input type="checkbox"/> PROGRESSION
TESTS <input type="checkbox"/> LABORATORY <input type="checkbox"/> X-RAY	TYPE(S) AND FREQUENCY		DATE OF LAST CHEST X RAY Y M D
RESPONSIBILITY FOR ONGOING MEDICAL SUPERVISION			TB SKIN TEST RESULT
PHYSICIAN'S NAME (PRINT)	ADDRESS	FOLLOW UP APPOINTMENT	Y M D
O.H.I.P. BILLING CODE	ADDRESS	TELEPHONE ()	
MEDICAL REFERRAL COMPLETED BY:			TELEPHONE ()
PHYSICIAN'S NAME (PRINT)	ADDRESS	DATE SIGNED Y M D	
O.H.I.P. BILLING CODE	ADDRESS		