MAPLE VIEW TERRACE
RETIREMENT RESIDENCE

HEALTH ASSESSMENT

Applicant's Name:_____

Date:_____

Completed By:_____

Telephone:_____

Fax:_____

E-mail:_____

Note: please include copy of prescriptions and one week's supply of medication if nurse is required to administer medication.

Please return the Health Assessment prior to move-in to:

Tel: (519) 434-4544 Fax: (519) 673-4971
Email: kathleen.granitto@trilliumretirementliving.com

OR **: jhalliday-dinon@trilliumretirementliving.com**

MAPLE VIEW TERRACE
HEALTH ASSESSMENT

Name of Applicant

Given Name:_____Initial:_____Surname:_____

Contact Name:(if other than the applicant):_____

Contact Phone# (Home):_____(Work):_____

(Cell)_____

Applicant Address

Number:_____Street:_____Apt:_____

City/Town:_____Province:_____Postal Code:_____

Telephone Number:_____

Birthdate:_____Health Card#:_____

Physical Assessment

As required by the RHRA a chest x ray for TB screening prior to move-in is required. The results can be faxed to Maple View Terrace.

Date of Last Chest X-Ray:_____Results:_____

Flu Vaccine/ Last date given:_____Pneumovac Vaccine given:_____

Creatinine level:_____

VRE/MRSA (please circle) yes no

Height_____Weight_____

Blood pressure:_____

Diet:_____

Has the applicant been hospitalized within the last 6 months: yes no
Reason:_____

Current
Diagnosis:_____
_____
_____
_____
_____

Previous illnesses:_____
_____
_____
_____
_____

Present medical findings:_____
_____
_____
_____

Smoker: yes no
Frequency:_____

Alcohol use: yes no
Frequency:_____

Medications

Capable of self-administering medications: yes no

Current medications:_____
_____
_____
_____
_____
_____
_____
_____
_____

Pharmacy name, telephone number, any special instructions:
_____
_____
_____
_____
_____
_____
_____
_____

Functional Assessment

Mental Status

Depressed: yes no Forgetful: yes no Confused: yes no

Previous psychiatric history: yes no

Comments:_____
_____
_____

Senses	Normal	Impaired	Deficits
Hearing			
Vision			
Speech			

Languages
Spoken:_____

Ambulation

Normal yes no Requires assistance yes no

Assistive Device(s):_____

History of Falls: yes no _____

Activities of Daily Living

ADL	Independent	Requires assistance	Comments
Eating			
Bathing			
Dressing			

Elimination	Normal	Incontinent	Comments
Bowel			
Bladder			

Reason for relocation to Retirement Residence:_____
_____
_____
_____
_____
_____

Physician Information

Name of Family Physician:_____

How long has the applicant been under the family Physician's care:_____

Address:

Number:_____Street:_____Suite:_____

City/Town:_____Province:_____Postal Code:_____

Telephone #:_____Fax #_____

Physician's signature_____

Physician's name:(print)_____

Date:_____

Consent to Communicate to an Authorized Person and Release of Personal Health Information

Trillium Retirement Living protects your privacy and complies with provincial privacy legislation. We will not release your personal health information until you provide consent.

By signing below, you consent to:

1. Name person(s) with whom you allow us to communicate regarding your care or how you are doing.
2. Allow our registered staff to contact the hospital, medical facility, doctor, and/or the Community Care Access Centre to inquire about your situation and to assess your needs when you return to Trillium Retirement Living if you are admitted or assessed.
3. Allow the treating facility, health practitioner, and/or case manager to share information with our staff - such information as your current state of health, medications, treatments, plan of care, and/or discharge plans.

The following person(s) have my permission for Trillium Retirement Living to release information to:

Name	Relationship	Phone Number
1. _____		
2. _____		
3. _____		