BAYVIEW RETIREMENT HOME
CONFIDENTIAL RESIDENT PREADMISSION MEDICAL RECORD

Name of Applicant

Given Name: _____ Initial: _____ Surname: _____

Address
Number _____ Street _____ Apt _____

City/Town _____ Province _____ Postal Code _____

Telephone No _____

Health Card No _____ Version Code _____Birth Date _____

PHYSICAL ASSESSMENT

Influenza Vaccine/Last Date Done: _____

Pneumococcal Vaccine Date: _____

Shingles Vaccine: _____

Tetanus Toxoid: _____

V.R.E. M.R.S.A _____

Mantoux Test I: Date: _____ Result: _____

Mantoux Test II: Date: _____ Result: _____

Date of Last Chest X-Ray: _____ Result: _____ Place taken: _____

Height: _____ Weight _____ BP _____ Pulse _____

ALLERGIES _____

Diet _____

Creatinine Level _____ EgFR _____Date: _____
(for anti-viral calculation)

Has the resident been
Hospitalized during past
6 months Yes: _____ No: _____

Comment: _____

Present Diagnosis _____

Past History

Medical

_____

_____

Surgical

_____

_____

Physical Examination:

Physical Findings of:	**Yes**	**No**	**Comment**
Eyes			
ENT			
Neck			
Thyroid			
Respiratory - Chest			
Lungs			
Alimentary (Upper/Lower G.I.)			
Spleen			
Breasts			
Heart Size			
Heart Rhythm			
Murmurs			
Abdomen			
Rectal Exam			
Peripheral Pulses			
Joints and Back			
Extremities			
Musculature - Skin			
Genito-urinary			
Nervous System			
Mental Status			
Endocrine/Diabetes			

Laboratory Investigation:

Detail Abnormalities of:

Urine: _____ Chest X-ray: _____

Hematology: _____ ECG: _____

Chemical Profile: _____

Physician's Assessment:

Resident	Yes	No	Details
Confined to bed?			
Confined to wheelchair?			
Able to walk? Uses walker?			
Able to dress unaided?			
Able to go to bathroom unaided?			
Mentally & emotionally stable?			
Is the resident able to administer own medications?			

Amplify in full where necessary

Physician Classification:

Physical Ability - Circle one

A. No limitation of normal physical activity
B. Noticeable reduction of physical function with brief periods of requiring assistance.
C. Marked limitation not requiring bed care.
D. Severe limitation requiring constant help and supervision and some bed care.

Mental Ability – Circle one

A. Complete retention of normal acuity and emotional balance
B. Reduced Mental Function – Brief Confusion
C. Noticeable reduction of mental function with brief periods of confusion and/or forgetfulness.
D. Marked confusion.
E. Persistent confusion and disorientation
F. Evidence of psychosis and delusions and/or hallucinations

Physician's Identification

Examining physicians printed name:_____

Address: _____

_____

Phone number: _____

Signature: _____ Date: _____

Thank you for completing the Medical Exam.

CURRENT MEDICATIONS

LIST OR ATTACH LIST OF ALL MEDICATIONS: Include dosage, frequency, route and date prescribed, treatments to be continued and Diet if applicable. Please sign at bottom of sheet. (This will become our initial Physician Order)

Name of Physician:_____Signature:_____Date: _____

Bayview's House Physician Comments

Signature: _____ Date: _____

Bayview's Nursing Comments

Admitted: Yes _____ No _____

Bayview's Administration Comments

Approved: _____ Not Approved: _____

Room Number: _____ or Waitlist: _____

Applicant Contacted to notify if the Application was Approved or Not:

_____

Signature: _____

Title: _____

Date: _____