MISSION ASSOCIATION FOR SENIORS HOUSING
7380 HURD STREET, MISSION, BC V2V 3H5

Assisted Living and Supportive Housing

PHYSICIAN INFORMATION REQUEST

Physician Name: _____

Phone Number: _____ **Fax Number:** _____

Address: _____

Patient's Name: _____

Current Address: _____

Diagnosis, current treatments, medical history: _____

_____

_____

Short-term memory: _____ Long-term memory: _____

Cognitive Skills for Daily Decision Making (independent, some impairment, severely impaired):

_____

Communication (making self understood – usually, sometimes, rarely/never): _____

_____

Coping Skills (ability to deal with emotional/physical stress or if depressed, agitated, anxious, etc.):

_____

Activities of Daily Living

Indoor Mobility: Uses cane ☐ Walker ☐ Wheelchair ☐ Outdoor Scooter ☐

Mobility issues day/night time (if different): _____

Transferring: Transfer into bed ☐ Transfer out of bed ☐ Other_____

Bed making ☐ Personal laundry ☐ Grocery Shopping ☐
Uses toilet ☐ Commode ☐ TED Stockings ☐
Uses incontinent products: _____

Incontinence awareness: _____

Special diet requirements: _____

Allergies: _____

_____

Medication Management

Current Medications: _____

_____

_____

Requires Assistance_____ Independent _____ Supervision_____

Notes: _____

Diabetic: Yes☐ No☐ Type: _____ Blood sugar check to be done: _____

Insulin: _____ Notes: _____

Oxygen: oxygen dependent ☐ portable oxygen tank ☐

Identified Risks (describe**)**

_____

_____

_____

_____

Physician Signature: _____ Date: _____