THE GLENSHIEL
606 DOUGLAS STREET
VICTORIA, BC V8V 2P8
Phone: (250) 383-4164 Email: executivedirector@theglenshiel.bc.ca

MEDICAL REPORT

EXAMINING PHYSICIAN:

1. **The Glenshiel offers housing with services and amenities, such as meals and housekeeping, to independent seniors. Residents must be capable of managing their own care with the supports provided by The Glenshiel and available community health care services.**
2. **MoCA score required.**
3. **All information submitted will be confidential.**
4. **I, ____ authorize medical information to be released to The Glenshiel. I am responsible for any costs associated with completion of the medical examination and associated paper work.**
5. **Please return the completed form to the Director, The Glenshiel Housing Society.**

Applicant's Name: ____

Address: ____

Birth Date: ______________________ **Sex:** ________ **BC Medical #**____

Examining Physician ____________________________________ **Date Examined** ____________________

How long has Applicant been under your care? ____

Diagnosis ____

____

Past History ____

____

____

Medications ____

____

Immunizations in last 5 years (type & date) ____

____

____

Diet ____

____

Allergies ____

____

ACTIVITIES OF DAILY LIVING

Please indicate if assistance is needed with the following:

	Assistance Needed	NO Assistance Needed
1. DRESSING	_______	_______
2. BATHING	_______	_______
3. FEEDING	_______	_______
4. AMBULATION	_______	_______

DOES THE APPLICANT

	YES	NO
5. USE A CANE	_______	_______
6. USE A WALKER	_______	_______
7. USE A WHEELCHAIR	_______	_______

Are there any mobility issues that we should be aware of i.e. history of falls? Please explain.

____

____

	YES	NO
8. HX OF ALCOHOL/DRUG ABUSE	_______	_______
9. CURRENT ALCOHOL/DRUG ABUSE PROBLEM	_______	_______
10. HX OF MEDICATION ABUSE	_______	_______
11. CURRENT MEDICATION ABUSE PROBLEM	_______	_______
12. HX OF DEPRESSION	_______	_______
13. HX OF MENTAL ILLNESS	_______	_______

IF THE ANSWER IS YES TO ANY OF THE QUESTIONS FROM 8-13, WHAT TREATMENT IS BEING SOUGHT?

____

____

	YES	NO
14. HX OF AGGRESSIVE BEHAVIOR	_______	_______

IF SO, THIS IS LIKELY TO BE TRIGGERED BY:

____

____

	YES	NO
15. BLADDER INCONTINENCE	_______	_______
16. BOWEL INCONTINENCE	_______	_______
IS THE APPLICANT MANAGING THEIR INCONTINENCE?	_______	_______

	YES	NO
17. VISUAL IMPAIRMENT	_______	_______
18. DIFFICULTY IN COMMUNICATION	_______	_______

IF YES, THIS IS DUE TO: ____

____

COMMENTS:____

____

____

RECOMMENDATIONS FOR A SUCCESSFUL TRANSITION TO SUPPORTIVE LIVING:

____

____

____

**PLEASE INDICATE MOCA SCORE: ____
(IF BLANK, APPLICATION WILL NOT BE ACCEPTED)

DATE: ______________________

PHYSICIAN'S SIGNATURE ________________________________

ADDRESS ________________________________

PHONE NUMBER ________________________________

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