THE GLENSHIEL
606 DOUGLAS STREET
VICTORIA, BC V8V 2P8
Phone: (250) 383-4164 Fax: (250) 388-0571

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. **All information submitted will be confidential.**
3. **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.**
4. **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 _____

_____

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:

_____

_____

_____

DATE: _____

PHYSICIAN'S SIGNATURE _____

ADDRESS _____

PHONE NUMBER _____