A Christian Seniors Lifestyle Community

The Meadows of Aurora

THE MEADOWS CONTINUUM OF CARE PERSONAL APPLICATION

THIS FORM SHOULD BE COMPLETED BY THE APPLICANT / POA.

Health Insurance

Ontario Health Card | Out of Province Health Card #

Version | Prov. ON | Gender ◉ Male ○ Female

Applicant

Surname | Given Names

Current Address | Apt. | Date of Birth (MM – DD – YYYY)

City | Prov. ON | Postal Code | Telephone

Demographics

Citizenship:
- ◉ Canadian Citizen
- ○ Landed Immigrant
- ○ Veteran Service #
- ○ Other

Marital Status:
- ◉ Single
- ○ Married
- ○ Common-Law
- ○ Divorced
- ○ Separated
- ○ Widowed

Religion

Languages Spoken 1st | 2nd

Accommodations Requested:
◉ Private ○ Semi-private ○ Couple

Contact Information

Family Physician

Surname | Given Names

Address | City: | Prov. ON | Postal Code

Office | Alt. | Cell | Fax

Contact # 1

○ Substitute Decision Maker
○ POA for Care (copy included).

Surname | Given Names

Address | City: | Prov. ON | Postal Code

Home | Cell | Work | Other

Email:

Contact # 2

○ Substitute Decision Maker
○ POA for Care (copy included)

Surname | Given Names

Address | City: | Prov. ON | Postal Code

Home | Cell | Work | Other

Email:

Financial Affairs

◉ Self ○ Other ○ Power of Attorney for Property (finances)

☐ POA for Care (copy included)

Surname | Given Names

Address | City: | Prov. ON | Postal Code

Home | Cell | Work | Other

Email:

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THE MEADOWS CONTINUUM OF CARE PERSONAL APPLICATION

Income (Note: Information may be required to be updated annually.)

Total Annual Income: (appearing on your last tax return)

Estimated Assets:

Out of the consideration for the safety and health of all, Continuum of Care at The Meadows of Aurora is a pet free and smoke free facility.

Please return to:
The Meadows of Aurora
440 William Graham Drive
Aurora,ON L4G 1X5

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THE MEADOWS CONTINUUM OF CARE MEDICAL APPLICATION

THE FOLLOWING SECTIONS ARE TO BE COMPLETED BY A PHYSICIAN

Date of Assessment: (MM – DD – YYYY)

Surname | Given Names

Current Address | City | Prov. ON | Postal Code

Ontario Healt Care Number | Date of Birth (MM – DD – YYYY) | Gender ◉ Male ○ Female

MEDICAL DIAGNOSIS

Diagnosis and date of onset:

PAST HEALTH HISTORY

Include medical, surgical, family, social, psychiatric, attach medical report or consultations if available.

RECENT HEALTH HISTORY

Has the applicant been seen by other health care providers (medical specialists, rehabilitation specialists, dieticians, social workers, etc.)? If so, describe the treatment outcome.

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HEALTH REPORT FOR ADMISSION TO THE MEADOWS CONTINUUM OF CARE

Social History Supports

List any drug sensitivities, allergies or addictions:

List current medications: (crushed or whole medications are taken)

Immunization Dates:

Mantoux Testing Results Step 1: Date: (dd-mm-yyyy)
Step 2: Date: (dd-mm-yyyy)

Date of most recent CXR (within 3 months) (MM – DD – YYYY) ☐ Chest x-ray report attached

☐ Pheumo vac: (MM – DD – YYYY) ☐ Flu vac ☐ Covid19 vac ☐ Tetanus

Physician's Information:

Address: Telephone:

Professional Designation:

Signature: Date Completed (MM – DD – YYYY)

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FUNCTIONAL ASSESSMENT FOR ADMISSION THE MEADOWS CONTINUUM OF CARE

THIS FORM SHOULD BE COMPLETED BY NURSE / CAREGIVER / FAMILY MEMBER

Surname: _____ Given Names: _____

D.O.B.: _____ Date: _____ (MM – DD – YYYY)

Ambulation

☐ Aids: ☐ N/A ☐ Cane ☐ Walker ☐ Crutches
☐ Wheelchair: ☐ Self-propelled ☐ Assisted ☐ Motorized
☐ Other

Assistance Required: ☐ On Level ☐ One Person ☐ Two Person
☐ To sit down ☐ Falls – Reason/Frequency _____
☐ Bedridden – please explain: _____

Transfer

◯ Independent ◯ Requires one-person assistance
◯ Requires supervision ◯ Requires two persons assistance
◯ Requires two person's assistance or mechanical aid
◯ Cannot weight bear

Limbs

◯ Normal ◯ Impaired Arm: ☐ Right ☐ Left
◯ Normal ◯ Impaired Leg: ☐ Right ☐ Left
No use of Arm: ☐ Right ☐ Left
Comment _____
◯ Independent with prosthesis ◯ Needs assistance with prosthesis
☐ Amputation (specify): _____

Bowel

☐ Full Control ☐ Occasionally Incontinent ☐ Using Incontinent Product
☐ Routine Toileting to Maintain Control
☐ Incontinent: _____
☐ Indwelling ☐ Retraining ☐ Continuous Bladder Irrigation
☐ Presently using Condom Catheter
☐ Will be removed prior to discharge
☐ In & Out –why? _____

Ostomy

◯ N/A ◯ Ability to care for ostomy: ◯ Independent ◯ Total Care
◯ Requires Supervision/Assistance

Dialysis

◯ N/A ◯ Hemodialysis
(Frequency/Days/Location): _____
◯ Peritoneal
(Type/Frequency/Facility): _____

Skin Condition

☐ Normal ☐ Incision ☐ Rashes ☐ Burn
☐ Decubitus Ulcer /Open Soars: Description: _____
Stage: _____
Size: _____
Location: _____
Prescribed Treatment: _____

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FUNCTIONAL ASSESSMENT FOR ADMISSION THE MEADOWS CONTINUUM OF CARE

Cognitive Function

- ◉ Unimpaired ○ Impaired Judgment
- Memory Loss: ○ Recent ○ Remote ◉ Forgetful:
  - ☐ Personal Hygiene
  - ☐ Electrical Devices
  - ☐ Medication
- ☐ Lacks Attention
- Disoriented to: ☐ Time ☐ Place ☐ Person
- Overall Impact on ADL: ○ None ○ Mild ○ Moderate ○ Severe
- Specify recent changes:

Behavioral

- ☐ Cooperative ☐ Cognitively Impaired but socially appropriate behavior
- ☐ Demanding* ☐ Resistive* When ☐ To Whom
- ☐ Disruptive* ☐ Aggressive* ☐ Wanders* ☐ Pacing ☐ Exit Seeking
- ☐ Depressed* ☐ Hoarding* ☐ Suspicion* ☐ Anxious ☐ Screams
- ☐ Paranoia* ☐ Sexual
- Repetitive*: ☐ Speech ☐ Movement
- Agitated*: ☐ Day ☐ Night ☐ Sundowning
- Abusive*: ☐ General ☐ Verbally ☐ Physical ☐ Specifically
- ☐ Disinhibition Behavioral Assessment Available

* Comprehensive behavioral assessment may be required

Notes:

Speech

- ☐ Adequate ☐ Aphasic/Dysarthri
- ☐ Language Barrier:
- Communicates: By
- With Difficulty
- Unable

Vision (with aid if worn)

- ☐ Adequate ☐ Blind ☐ Glasses
- Cataracts: ○ Operable ○ Inoperable
- ☐ Glaucoma ☐ Macular degeneration
- ☐ Able to read a medication bottle ☐ Drive a car
- ☑ Other (Specify):

Hearing

- ☐ Adequate ☐ Impaired ☐ Deaf ☐ Left ☐ Right ☐ Tinnitus
- Hearing aids ○ N/A ○ Both ○ Left ○ Right
- Other (Specify):

Ability to Eat

- ○ Independent ○ Dependent ☐ Supervision ☐ Set up ☐ Cueing
- ☐ Requires Assistance ☐ Difficulty Chewing ☐ Difficulty Swallowing
- ☐ Nasogastric Tube
- Dentures: ○ Partial ○ Full
- ☐ Gastrostomy Tube – schedule/Type:
- ☐ Dietary Requirements:

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Ability to Dress
- ◉ Independent ○ Reluctant ○ Dependant ○ Cueing
- ☐ Requires Supervision (Specify):
- ☐ Requires Assistance (Specify):

Ability to Bathe or Wash
- ◉ Independent ○ Refuses ○ Dependant ○ Cueing
- ☐ Requires Supervision (Specify):
- ☐ Requires Assistance (Specify):

Sleep
- ☐ Sleeps most of the night ☐ Noisy
- ☐ Has difficulty sleeping (Specify):
- ☐ Currently receiving sedation (Specify):

Safety Requirements
- ○ N/A
- ○ Restraints Why? When?
- ☐ Physical ☐ Chemical ☐ Bed Rails ☐ Geri Chair
- ☐ Currently in Secured Unit

Special Needs
- ☐ N/A
- ☐ Suction (Frequency): ☐ Oxygen Ventilator
- ☐ Tracheotomy
- ☐ Glucometer Checks (Frequency):
- ☐ Other (Specify):
- Precautions Required: ☐ VRE ☐ MRSA
- ☐ Other Precautions Required:

Smoking
- ◉ Yes
- ○ No
- ○ Quit – How long ago?

Overall Care Level
- ○ Light ○ Medium ○ Heavy ○ Wander Alert
- ○ Secure Unit Required

Personal Data
- Approximate Height: Approximate Weight: (lbs)
- B/P Range: Respiratory Rate:
- Heart Rate: D.O.B. (mm/dd/yyyy)

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FUNCTIONAL ASSESSMENT FOR ADMISSION THE MEADOWS CONTINUUM OF CARE

Previous Health History:

Recent Health History:

Current Medications:

Source of Information:
(i.e., Physician, Registered Nurse)

Form Completed by (Please Print)

Professional Designation: Telephone:

Signature: Date Completed
(MM – DD – YYYY)

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