

MEDICAL ASSESSMENT FORM

Queensway Place Assisted Living
799 Queensway, Espanola, Ontario P5E 1R4
Phone (705)869-1420 extension 4090
Fax (705)869-2608

This form is required as part of the application process for Queensway Place Assisted Living and is to be completed by a health care practitioner.

Please enclose copies of any relevant reports

Please note: A medical form needs to be completed for **each applicant.** *Please print clearly.*

| | |
|---|--|
| Applicant Name | |
| Date Of Birth | |
| Pertinent Diagnoses/Medical History | |
| Prognosis | |
| Medications: (Attach a list if more room is needed) | |
| | |

History of smoking? Current smoker? _____

Alcohol intake? _____

Use of other non-prescription substances? _____

| | |
|---|--|
| Cognitive Status/Behaviours (e.g. wandering, confusion, hoarding, etc.) | |
| | |
| Mini Mental Status Examination Score | |
| MOCA Examination Score | |

| | |
|---|--|
| This information will be used to ensure that Queensway Place is the appropriate place for the applicant to live. Queensway Place only offers housekeeping, laundry, and meal preparation services. Does the applicant need assistance with? | |
| <input type="checkbox"/> | Standing or Transfer to/from Wheelchair |
| <input type="checkbox"/> | Walking (even with assistive devices such as canes or walkers) |
| <input type="checkbox"/> | Dressing |
| <input type="checkbox"/> | Bathing |
| <input type="checkbox"/> | Medication reminders |
| <input type="checkbox"/> | Paying bills |
| Is there any other information that may be relevant to the applicant's ability to live independently? | |
| | |

| | |
|--------------------------------------|--|
| Name of Healthcare Practitioner | |
| Telephone | |
| Signature of Healthcare Practitioner | |
| Date | |

PLEASE NOTE: PATIENT IS RESPONSIBLE FOR CHARGES INCURRED WITH THE COMPLETION OF THIS FORM.