Parkland™
LIFESTYLE RESIDENCES
ON EGLINTON WEST

Dear Physician,

Your patient is a future resident of Parkland on Eglinton West. Parkland on Eglinton West is a Lifestyle Residence that offers Independent Lifestyles, Assisted Living, Memory Care, and Enriched Care accommodations to our residents. Our licenced care team provides services along the continuum, up to end of life care so our residents can age in place.

As a requirement for move-in, we request that you provide a brief medical history for your patient by completing the following forms and attaching any relevant documentation. Residents are aware that this may be at a cost to them.

The information you provide is important to us in affording quality service and care to our residents. Making sure we can best meet their needs is best assessed with your assistance.

Our goal is to work in partnership with you to support the care provided to your patient during their stay at Parkland on Eglington West.

With thanks,

Abigail Beveridge
Lifestyle Consultant
T: 416-997-2647
F: 647-366-3911

Parkland on Eglinton West
4650 Eglinton Ave W
Etobicoke, ON
M9A 0E3
www.experienceparkland.com

PHYSICIAN'S STATEMENT (ASSESSMENT)

Patient's Legal Name:	
Date of Birth (dd/mm/yyyy):	Health Card Number:

MEDICAL HISTORY AND RELEVANT DIAGNOSIS

(attach additional documentation as needed)

Diagnosis and Date	**Diagnosis and Date**

Food and drug allergies/sensitivities and reactions:

_____

MENTAL HEALTH

History of mental health condition(s): _____

Risk to self: _____

Risk to others: _____

Exit Seeking/Wandering:_____

Other Responsive Behaviour(s): _____

Diagnosis of Cognitive Impairment: _____Date: _____

MMSE/MOCA Score: _____Date of Assessment:_____

History of Alcohol/Drug abuse or alcohol restrictions: _____

General Appearance and Mental Status: _____

Patient's Legal Name:	
Date of Birth (dd/mm/yyyy):	Health Card Number:

FUNCTIONAL CAPACITY: AMBULATION AND TRANSFERS

Normal: ☐ Abnormal: ☐ Walker: ☐ Cane: ☐ Wheelchair: ☐

Transfer Assistance Required:

- ☐ 1 person
- ☐ 2 person
- ☐ Mechanical Lift
- ☐ Other:_____

- ☐ Needs asistance with transfer in/out of chair
- ☐ Needs assistance with transfer in/out of bed
- ☐ Needs assistance with transfer on/off toilet
- ☐ Needs assistance with transfer in/out of shower/bath

History of Falls: _____

ACTIVITIES OF DAILY LIVING REQUIRING ASSISTANCE (Please check the ADLs that require assistance)

- ☐ Dressing
- ☐ Bathing
- ☐ Toileting
- ☐ Laundry
- ☐ Housekeeping
- ☐ Meal preparation

ELIMINATION

Continent of bladder: Yes ☐ No ☐ Comments: _____

Continent of bowel: Yes ☐ No ☐ Comments: _____

NUTRITIONAL STATUS

Therapeutic Diet:_____ Dysphagia: _____

Dental Issues:_____ Supplements: _____

Patient's Legal Name:	
Date of Birth (dd/mm/yyyy):	Health Card Number:

MANDATORY MOVE-IN REQUIREMENTS (Please attach)

☐ TB Screening within 90 days of move-in (Chest X-ray (as per RHRA, 2010) **OR** 2 step skin test)
Skin Test Result #1: _____
Skin Test Result #2: _____
OR
CXR Result (please specify whether negative or positive for TB): _____
(Please attach CXR results/report indicating result)

☐ Please attach **PRESCRIPTIONS**, signed by the physician
Does your patient require support with medication administration? ☐ Yes ☐ No

☐ Immunization Status/List of vaccinations

☐ Standing Order for Flu Vaccine – By checking this box, I authorize the administration of the seasonal flu vaccine by RN/RPN as per best practice

NOTE: Please attach any additional medical and consultation notes that may support our understanding of and ability to care for this client.

Physician's Name (printed): _____

Physician's Signature: _____

Date of completion: _____

Phone: _____ Fax: _____

PLEASE FAX TO PARKLAND LIFESTYLE RESIDENCES
Attention: Abigail Beveridge
Fax number: 647-366-3911
Main phone: 416-997-2647

Fax

To: _____ From: _____

Fax #: _____ Pages: _____

Phone #: _____ Date: _____

RE: _____ CC: _____

☐ Urgent ☐ For review ☐ Please comment ☐Please reply

Comments:

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