Physician's Assessment

Resident Name: _____ DOB: _____

Health Card Number: _____ Sex: M/F/X

Current Address: _____

City: _____ Postal Code: _____

Height: Weight: Significant weight loss last 12 months? Y/N

Allergies:

Past Medical History:

Past Surgical History:

Health Consults (ie: OT, PT, SLP, SW, Geriatric Mental Health, etc.)

Specialists involved in Resident's care (ie: Cardiologist, Neurologist, Nephrologist, etc.)

Please discuss and **attach** goals of care designation paperwork and submit with this report.

Please discuss with patient if they are taking any OTCs and provide orders for same.

Please provide orders for the following Standing Orders even if the resident is independent with their medications.

Please Attach Current Medication Orders and Immunization Records

Please answer the following questions in regards to the above named patient:

Fall Risk?	
Memory Impairment? If yes, does it impact their ability to make safe decisions?	
Wandering? Does the patient require a secured unit?	
Aggression/Agitation? If yes, any treatment plans currently in place?	
Other Behavioural Concerns? If yes, any treatment place currently in place?	
History of Drug or Alcohol Abuse? If yes, can resident continue to make decisions regarding alcohol or drug consumption?	
Currently or History of Smoking?	
Vision Changes? If yes, any devices?	
Hearing Changes? If yes, any devices?	
Sleeping Challenges? If yes, how is resident managing?	
Ambulatory? Devices used or recommended? If yes, what?	
Continent? If no, frequency and type of incontinence?	
Catheter and/Ostomy? If yes, please provide orders for changing catheter and/or ostomy for nursing team	
Oxygen Requirements? If yes, please provide orders for flow rate and O2 saturations If yes, who is supplier?	
Immunocompromised?	
Diet or Swallowing Concerns? If yes, what diet modifications are required?	

STANDING ORDERS

Name: _____ DOB: _____ PHN: _____

☐ For Mild Allergic Reaction
- diphenhydrAMINE 25 - 50mg orally every 6 hours as needed

☐For Anaphylaxis
- epINephrine autoinjector 0.3mg Intramuscularly. **Call 911 and contact physician**
- Repeat every 15 minutes if required. Max 2 doses

☐For Cold Symptoms for a maximum of 72 hours
- Acetaminophen 325mg-650mg orally every 4 hours as needed (maximum of 4 grams from **all sources** in 24 hours)
- Fisherman's Friend Lozenges orally for sore throat as needed.

☐For Skin Excoriation
- Barrier/Zinc/Baza Cream; apply to affected area Twice Daily and as needed with toileting.

☐For Pain
- Acetaminophen 325mg-650mg orally every 4 hours as needed (maximum of 4 grams from **all acetaminophen** sources in 24 hours)

☐For Constipation **If after provided with prune juice and water no BM**
- PEG 3350 17g orally daily, as needed
- Lactulose 15mL-30mL-orally daily, as needed if PEG no effective
- Glycerin or bisacodyl 10mg suppository rectally once if no Bowel Movement in 3 days.
- Enemol Fleet Enema once if no Bowel Movement in 3 days and suppository is not effective.

☐For Nausea
- Ginger Gravol take 2 tablets every 4 hours up to 3 times daily

☐For Heartburn
- Calcium Carbonate (TUMS) 500mg chewable tab. Chew 1-2 tabs as needed. Do not take more than 6 tablets/24 hrs.

☐For Diarrhea for a maximum of 48 hours. **Do not use loperamide with GI Outbreak, and if Clostridium Difficile (C. Diff) is suspected**
- Loperamide 4mg orally STAT and then 2mg after each loose stool up to 16mg in 24 hours.
- Bland Diet and encourage hydration

☐Standing Orders for routine care/treatments on an ongoing basis
- If assessed for wax in ears, **notify Physician/Case Manager** to initiate Cerumol to ears nightly for 7 days then elephant ear syringe as needed.

If the resident does not respond to treatment, or the condition deteriorates, notify Physician/Case Manager.

If the resident uses standing orders frequently, notify Physician/Case Manager .

Physician Signature: _____ *Physician Name:* _____

Thank you very much for your assistance in this matter. All reports are kept strictly confidential. Information Provided allows the Origin Team to provide appropriate and quality care to the Resident. Please do not hesitate to contact us directly if you have any questions or concerns.

Physician to Complete

I certify that this statement is made to the best of my knowledge and information

Signature of Physician: _____

Printed Name of Physician: _____ Date: _____

Address: _____

City: _____ Postal Code: _____

Office Phone: _____ Email : _____

Office Fax: _____

Office Use Only

Received and Reviewed by Origin at Spring Creek:

Signature: _____ Name: _____

Title: _____ Date: _____

Comments:

_____

_____

_____

Leasing Notified Date: _____

Assessment Booked Date : _____

☐Accepted ☐Declined