The Country Manor Estates

COUNTRY MANOR ESTATES

BETTER LIVING BEGINS HERE

Pre-Admission Forms

Please hand in prior to moving in

Residents must fill out the following two forms and turn into management's office prior to move-in or on the move-in date:

1. RC 4.1.1 Initial Assessment – Pre-Admission Information
2. Trust Care Admission Form Pharmacy

RC 4.1.1 Initial Assessment – Pre-Admission Information

Interview Date:		
Name:		
Surname	First	Initial
Address:		
City/Postal Code:		
Telephone:		
Health Card #:	Birth Date:	
Birthplace (city/country):		
Language:	Religion:	
Status (S/M/W/D):	Spouse's Name:	
Contact # 1		
Name:	Relationship: ☐ SDM ☐ POA-PC ☐ POA-FC ☐ NOK ☐ Family ☐ Friend	
Address:	Phone (home):	
City/Postal Code:	Phone (business):	
Contact # 2		
Name:	Relationship: ☐ SDM ☐ POA-PC ☐ POA-FC ☐ NOK ☐ Family ☐ Friend	
Address:	Phone (home):	
City/Postal Code:	Phone (business):	
Power of Attorney		
Power of Attorney (Care):	Relationship:	
Address:	Phone:	
City/Postal Code:		
Power of Attorney (Financial):	Relationship:	
Address:	Phone:	
City/Postal Code:		
Physician Name:		
Address:	Phone:	
City/Postal Code:		

ADMISSION FORM PHARMACY (Resident)

TRUSTCARE PHARMACY
A member of *your* Care Team

Home _____ Date Admitted _____

Resident _____ _____
Family Name First Name(s)

Unit No _____ Room No _____ Bed No _____ Birth Date ____/____/____
MM DD YY

Physician _____ Gender M/F _____
Last Name First Name

Resident's previous Pharmacy Name _____ Phone (____) _____

Resident Self-Medicates ❑ Yes ❑ No

If yes, medication to be in: ❑ Blister ❑ Vials ❑ Strips ❑ Snap cap (non safety)

DRUG PLAN COVERAGE (Include photocopy of Health Card or Other Benefit Information)

1) Health Card Number ☐☐☐☐-☐☐☐-☐☐☐ Version Code _____

2) Other Drug Insurance Fax copy of the card to pharmacy:
eg. Veterans Affairs, Greenshield, Liberty Health, Assure, ESI, or other

ID # _____ Carrier # _____

Group # _____ Subscriber _____

MEDICAL INFORMATION

Allergies / Sensitivities _____

Medical Conditions _____

Diet _____

Physician's Medication Reviews will be sent as per facility schedule unless requested otherwise.

INVOICING INFORMATION - IMPORTANT – MUST BE COMPLETED IN FULL

For prescription drug charges, copays, and personal supplies:

❑ Bill directly to Resident ❑ Bill to Family or Responsible Party

Name _____ Relationship _____
Family Name First Name

Address _____
Street City Province

Postal Code _____ Phone: Home: (____) _____ Business: (____) _____

- **FAX or phone this information to TrustCare Pharmacy WITH ADMISSION ORDERS**
- **Send this form in Pharmacy pick-up when INVOICING INFORMATION is complete**

❑ **Check after faxed to pharmacy Fax: 1-416-679-1014**

WE REQUIRE ALL PRESCRIPTIONS TO BE FAXED IN FOR RESIDENTS 2 DAYS PRIOR TO ARRIVAL. THEY NEED TO BE FILLABLE SCRIPTS FAXED IN NOT A MEDICATION LIST. ALL MEDS HAVE TO COME INTO THE MANOR BLISTER PACKED BY OUR PHARMACY IF RESIDENTS WILL HAVE COUNTRY MANOR DISTRIBUTE THEIR MEDS. IF THEY ARE SELF MEDICATED THIS DOES NOT APPLY.

THANK YOU

PRE-ADMISSION

PHYSICIAN'S STATEMENT

Date_____

Dear Physician,

_____ has applied for admission to **The Country Manor Estates Retirement Residence.** To assist in providing her/him with services to best meet her/his needs, we request your assistance by providing us with accurate medical history. We thank you in advance.

Please complete the following form and return it to the below address, or send with your patient.

Country Manor Estates Retirement Residence & Assisted Living
66 Victoria Street
Thedford, ON
N0M 2N0
Phone: +1(519)-296-4919
Fax: +1(519)-296-5715
Email: CManorEstates@gmail.com

Thank You.

Name of Applicant

Given Name: _____ Initial: _____ Surname: _____

Address
Number _____ Street _____ Apt _____

City/Town _____ Province _____ Postal Code _____

Telephone # _____

Health Card # _____ D.O.B. _____

PHYSICAL ASSESSMENT

Flu Vaccine/Last Date Done: _____

Pneumovac Vaccine Date: _____

V.R.E. M.R.S.A _____

Mantoux test I: Date: _____ Result: _____

Mantoux test II: Date: _____ Result: _____

Date of Last Chest X-Ray: _____ BP: _____

Height: _____

Weight: _____ Diet _____

Creatinine Level _____ Date: _____
(For anti-viral calculation)

Current Treatment / Lab work
Services in Use: _____

Has the resident been?
Hospitalized during past
6 months? Yes: _____ No: _____

Able to Self-Medicate Yes: _____ No: _____

Medical Assessment: Brief Medical/Surgical History (include recent health problems):

CONFIDENTIAL MEDICAL INFORMATION FOR
PHYSICIAN TO COMPLETE

Current Medications: (include dosage, frequency, route and date prescribed)

Medication	Dosage	Frequency	Route	Date Prescribed

Note any drug sensitivities and side effects, _____
Allergies or addictions: _____

Physician Name: _____

Address: _____ Phone #:_____

Physician Signature: _____ Date: _____

I give permission to my Physician to conduct this physical examination, to complete this form and to provide all information that is pertinent to my medical history.

Signature of Patient_____

Witness: _____ Date: _____

Assessment

Senses	Adequate	Impaired	Aids Used
Hearing			
Vision			
Speech			
Ambulation	Independent ☐	Requires Assistance ☐	Assistive Device ☐ **Specify:**
History of Falls:			

Continence	Normal	Incontinent
Bowel		
Bladder		
Activities of Daily Living	Independent	Requires Assistance
Eating		
Bathing		
Dressing		
Toileting		
Cognitive Ability		
☐ Alert	☐ Forgetful	
History of Wandering/Elopement	☐ Yes	☐ No

Medication and Other Substances			
☐ Self administers	☐ Administered by care giver	☐ Uses a dosette	☐ Injections
History or Harmful Behaviours		☐ Yes	☐ No
Specify:			

Special Diet:	
Allergies:	Medication:
	Food:
Current Diagnosis:	
Previous Illness:	
Previous Surgeries:	
Any Known Infectious Disease:	
T.B. Testing: ☐ Yes	☐ No
Smoker: ☐ Yes	☐ No
Alcohol Use: ☐ Yes	☐ No

I _____ of
(Please print, Last name, First name, initials)

_____
(Address)

dated on _____, have discussed the
(MM/DD/YYYY)

implications with Dr. _____ and I request not to be resuscitated upon my death. I understand that I will be given full medical care/treatment for all illnesses before such time.

_____	_____
Doctor's signature	Resident's signature
_____	_____
Date	Date
_____	_____
Witness signature	POA
_____	_____
Date	Date

Influenza Vaccine and Anti-viral Consent

The National Advisory Committee on Immunization (NACI) recommends an annual influenza vaccination for persons over 65 years of age, for adults with some chronic diseases, and for people, of any age, who live in a chronic care facility.

Influenza Vaccine

The vaccine is made from killed-influenza A and B viruses. Because these viruses change from year to year, influenza vaccine must be given annually. The vaccine does not prevent all upper respiratory infections, only those caused by the Influenza A and B viruses contained in the vaccine.

Studies among elderly persons residing in nursing homes have shown that the vaccine is quite effective in reducing influenza and influenza related pneumonia.

Influenza vaccine cannot cause influenza because the vaccine does not contain the live virus. There may be soreness at the injection site lasting up to 2 days. Fever, malaise and aching muscles may occur 6-12 hours after the injection and last 1-2 days. Immediate allergic reactions such as hives, swelling of the lips or tongue or acute breathing difficulty occur rarely.

Influenza vaccine should not be given if the patient has an allergy to eggs, has had a reaction to a previous administration of influenza vaccine, or if the individual has an acute infection or fever.

Antiviral Prophylaxis

The Medical Officer of Health and the Community Health Services Department will advise the Country Manor of the recommendations of antiviral use during an influenza outbreak. In many cases it is recommended for the staff and residents to be placed on prophylactic doses of an antiviral medication. Further information will be given at the time of an outbreak to assure that the most current treatment plan is followed.

Further information is available from your physician, upon request.

I have read and understand the above information on the influenza vaccine. I have been given an opportunity to ask questions which were answered to my satisfaction.

I hereby consent to the administration of:

1. Influenza vaccine once every year.
2. Antiviral treatment or prophylaxis

_____
Signature of the resident

When the resident is unable to give consent:

_____ _____
Relationship Signature of substitute decision maker

_____
Witness, RN / Physician

Dated at Thedford - _____
Day Month Year