The Meadows of Aurora

A Christian Seniors Lifestyle Community

THE MEADOWS CONTINUUM OF CARE
PERSONAL APPLICATION

This form should be completed by the Applicant / POA.

Health Insurance	Ontario Health Card Version		Out of Province Health Card # Prov.
Applicant	Surname	Given Names	Gender ❑ Male ❑ Female
	Current Address Apt.	Date of Birth	(MM – DD – YYYY)
	City Prov.	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	Office: ( ) ______________ Alt.: ( )
	Address		Cell ( ) ______________ Fax ( )
	City:	Province:	Postal Code:
Contact # 1 ❑ Substitute Decision Maker ❑ POA for Care (copy included)	Surname	Given Names	Home: ( ) ______________ Cell: ( )
	Address		Work ( )______________ Other ( )
	City:	Province:	Postal Code:
	Email:		
Contact # 2 ❑ Substitute Decision Maker ❑ POA for Care (copy included)	Surname	Given Names	Home: ( ) ______________ Cell: ( )
	Address		Work ( )______________ Other ( )
	City:	Province:	Postal Code:
	Email:		
Financial Affairs ❑ POA for Property (copy included)	❑ Self ❑ Other ❑ Power of Attorney for Property (finances)		
	Surname	Given Names	Home: ( ) ______________ Cell: ( )
	Address		Work ( )______________ Other ( )
	City:	Province:	Postal Code:
	Email:		

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 Meadowsof 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: ______________________

Last Name	Address	
Given Name(s)	City Prov. Postal Code	
Ontario Heath Care Number	Date of Birth (mm/dd/yyyy)	Sex ❑ 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.

-
-
-

HEALTH REPORT FOR ADMISSION TO THE MEADOWS CONTINUUM OF CARE

Surname: ___________________________ Given Name(s): _______________________

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:_________________
  Step 2:_________ Date:_________________
- Date of most recent CXR (within 3 months) ❑ Chest x-ray report attached
- ❑ Pheumo vac:_____________
- ❑ Flu vac: ❑ Covid19 vac: ❑Tetanus:

Physician's Information:

Address:____ Telephone: (____)_________________

Professional Designation: ________________________________

Signature: ___________________________________Date Completed (dd-mm-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: ______________________

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 ❑ Comment____________
Impaired Leg: ❑ Right ❑ Left ❑ Comment____________
No use of Arm: ❑ Right ❑ Left ❑ Comment____________
Impaired Leg: ❑ Right ❑ Left ❑ Comment____________
❑ Independent with prosthesis
❑ Needs assistance with prosthesis
❑ Amputation (specify): ______________________________

Bowel ❑ Full Control ❑Occasionally Incontinent
❑ Routine Toileting to Maintain Control ❑ Using Incontinent Product
❑ Incontinent: ____________________
❑ Catheter: ❑ Indwelling ❑ Presently using Condom Catheter
❑ Continuous Bladder Irrigation ❑ Will be removed prior to discharge
❑ Retraining ❑ 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 ❑ Foot Care ❑ Decubitus Ulcer/Open Soars:____________________
Description: ______________________________
❑ Normal Stage: ______________________________
❑ Incision Size: ______________________________
❑ Rashes Location: ______________________________
❑ Burn Prescribed Treatment: ______________________________

FUNCTIONAL ASSESSMENT FOR ADMISSION
THE MEADOWS CONTINUUM OF CARE

Surname: ____________________________ Given Names: _______________________
D.O.B.: ____________________________ Date: _______________________

Cognitive Function: Unimpaired Impaired Judgment Lacks Attention

Memory Loss: ❑ Recent ❑ Remote ❑ Forgetful: ❑ Personal Hygiene
❑Electrical Devices
❑Medication

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*
❑ Depressed* ❑ Wanders* ❑ Exit Seeking ❑ Pacing
❑ Repetitive*: ❑ Speech ❑ Movement
❑ Agitated*: ❑ Day ❑ Night ❑ Sundowning
❑ Abusive*: ❑ General ❑ Verbally ❑ Physical ❑ Specifically
❑ Hoarding*
❑ Suspicion* ❑ Anxious ❑ Screams
❑ Paranoia* ❑ Sexual Disinhibition
❑ Behavioral Assessment Available

❑ * Comprehensive behavioral assessment may be required
Notes:
____
____
____

Speech ❑ Adequate ❑ Aphasic/Dysarthric
❑ Language Barrier: _______________________________________
Communicates: ❑ By _______________________________________
❑ With Difficulty _______________________________________
❑ Unable_______________________________________

Vision ❑ Adequate ❑ Blind ❑Glasses ❑Cataracts: ❑ Operable ❑ Inoperable
(with aid if worn) ❑ Glaucoma ❑ Macular degeneration ❑ Do you drive a car?
❑ Are you able to read a medication bottle?
❑ Other (Specify): _______________________________________

Hearing ❑ Adequate ❑ Impaired ❑ Deaf ❑Left ❑ Right ❑Tinnitus
Do you wear hearing aids? ❑ yes ❑no (Right / Left / Both)
❑ Other (Specify): _______________________________________

Ability to Eat ❑ Independent ❑ Dependent ❑ Supervision ❑ Set up ❑ Cueing
❑ Requires Assistance ❑ Difficulty Chewing
❑ Difficulty Swallowing ❑ Dentures: ❑Partial ❑ Full
❑ Nasogastric Tube
❑ Gastrostomy Tube – schedule/Type: _______________________________
❑ Dietary Requirements:_______________________________________

FUNCTIONAL ASSESSMENT FOR ADMISSION TO THE MEADOWS CONTINUUM OF CARE

Surname: ____________________ Given Names: ____________________
D.O.B.: ____________________ Date: ____________________

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
❑ Tracheotomy ❑ Ventilator
❑ Glucometer Checks (Frequency): ____________________
❑ Other (Specify): ____________________

Precautions Required: ❑ VRE ❑ MRSA ❑ Other: ____________________

Other 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): ___________

FUNCTIONAL ASSESSMENT FOR ADMISSION TO THE MEADOWS CONTINUUM OF CARE

Surname: ______________________ Given Names: ______________________
D.O.B.: ______________________ Date: ______________________

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 (dd-mm-yyyy) ______________

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