

## Medical Assessment for Admission to Gunn Centre

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Personal Health Care Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ Pulse: \_\_\_\_\_ Respiration: \_\_\_\_\_ Temperature: \_\_\_\_\_

Allergies or Reactions:     Medications     Food     Environment (dust, pollen, pets)

### Medical History (If you answer yes to any of these questions, please explain in the “Explanation of History” box

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Central Nervous System Disorder (i.e. memory loss, poor concentration, peripheral neuropathy) | <input type="checkbox"/> Chronic Bronchitis, Asthma, COPD              | <input type="checkbox"/> Heart Conditions/ Angina | <input type="checkbox"/> Gastrointestinal Issues (GERD)   |
| <input type="checkbox"/> Liver Concerns  | <input type="checkbox"/> Kidney disease / urinary issues/kidney stones | <input type="checkbox"/> HIV and AIDS             | <input type="checkbox"/> Diabetes/Hypoglycemia            |
| <input type="checkbox"/> Epilepsy/Withdrawal Seizures  | <input type="checkbox"/> Chronic Pain                                  | <input type="checkbox"/> Eating disorders         | <input type="checkbox"/> Sleep disorders                  |
| <input type="checkbox"/> Suicidal Ideation or attempts   | <input type="checkbox"/> Mobility restrictions                         | <input type="checkbox"/> Addictions               | <input type="checkbox"/> Arthritis                        |
| <input type="checkbox"/> Bleeding problems/blood clots   | <input type="checkbox"/> Cancer/Leukemia                               | <input type="checkbox"/> CVA                      | <input type="checkbox"/> Depression/mood swings           |
| <input type="checkbox"/> Psychiatric treatment   | <input type="checkbox"/> Eye problems (not glasses), Glaucoma          | <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Fractures                        |
| <input type="checkbox"/> Gout  | <input type="checkbox"/> Headaches                                     | <input type="checkbox"/> Hepatitis A              | <input type="checkbox"/> Hepatitis B                      |
| <input type="checkbox"/> Hepatitis C   | <input type="checkbox"/> High Cholesterol                              | <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Night Sweats                     |
| <input type="checkbox"/> Prostrate problems  | <input type="checkbox"/> Sexually Transmitted Disease                  | <input type="checkbox"/> Thyroid                  | <input type="checkbox"/> Recent surgeries/serious illness |
| <input type="checkbox"/> MRSA  | <input type="checkbox"/> Coughing up blood or blood stained sputum     | <input type="checkbox"/> Fever (low grade)        | <input type="checkbox"/> Fatigue                          |
| <input type="checkbox"/> Poor appetite and/or weight loss  | <input type="checkbox"/> Any other notable medical concerns            |   |   |

### Explanation of Medical History (Please provide more detailed information for the above checked boxes)

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**Laboratory Results:** (Results are mandatory for review of final approval prior to admission)

*PLEASE HAVE RESULTS FAXED TO GUNN CENTRE AT (780) 967-3494*

CBC-D	<input type="text"/>	CREATINIME	<input type="text"/>	BILIRUBIN	<input type="text"/>	GGT	<input type="text"/>	ALT	<input type="text"/>
INR	<input type="text"/>	HEP C	<input type="text"/>	HIV	<input type="text"/>	HEP B	<input type="text"/>	CHEST X-RAY OR MANTOUX	<input type="text"/>

**Special Concerns and/or Issues** (i.e. physical, psychological)

PLEASE DESCRIBE ANY OTHER HEALTH ISSUES YOU MAY HAVE.

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**Current Medications**

Medication:	<input type="text"/>	Dose	<input type="text"/>	Start	<input type="text"/>	End	<input type="text"/>
		/Route:	<input type="text"/>	Date:	<input type="text"/>	Date:	<input type="text"/>
Medication:	<input type="text"/>	Dose	<input type="text"/>	Start	<input type="text"/>	End	<input type="text"/>
		/Route:	<input type="text"/>	Date:	<input type="text"/>	Date:	<input type="text"/>
Medication:	<input type="text"/>	Dose	<input type="text"/>	Start	<input type="text"/>	End	<input type="text"/>
		/Route:	<input type="text"/>	Date:	<input type="text"/>	Date:	<input type="text"/>
Medication:	<input type="text"/>	Dose	<input type="text"/>	Start	<input type="text"/>	End	<input type="text"/>
		/Route:	<input type="text"/>	Date:	<input type="text"/>	Date:	<input type="text"/>

Physician:  Date:

Please print or stamp Physician's name:

This information is being collected under section 33 (c) of the Freedom of Information and Protection of Privacy Act and will be protected under the provisions of the Act. Should you have any questions about the collection of this information, you may contact the FOIP Coordinator of Alberta Housing and Urban Affairs at (780) 427-1114 or 18<sup>th</sup> Floor, Commerce Place, 10155 – 102 Street, Edmonton, AB T5J 4L4.



Resident Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

PHN: \_\_\_\_\_

Allergies: \_\_\_\_\_

**PLEASE MARK STANDING ORDERS USING “YES” OR “NO” RESPONSES WHERE APPLICABLE.**

1.	INSECT BITE	YES	NO
	<b>Mild</b> – Calamine or Benadryl lotion	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Severe local</b> – Calamine or Benadryl lotion and Benadryl 50 mg p.o. q6h	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Severe Systemic</b> – Benadryl 50 mg – i.m. or p.o. Epinephrine 1 cc. Subcutaneous and send to hospital	<input type="checkbox"/>	<input type="checkbox"/>
2.	COLDS		
	Analgesic / Antipyretic	<input type="checkbox"/>	<input type="checkbox"/>
	Acetaminophen 325 mg – iii capsules – 4 qh PRN	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Cough Mixture</b> Robitussen DM 5 – 10mls – q6 h PRN over 24 hours	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Sore Throat</b> Gargle with salt/water mixture (1/2 tsp salt / 8 ounces warm water)	<input type="checkbox"/>	<input type="checkbox"/>
3.	CONSTIPATION		
	Colace (stool softener) I – 11 capsules given in a.m. or noon (maximum of 5 capsules)	<input type="checkbox"/>	<input type="checkbox"/>
	Senokot (laxative) ii –iv tablets at hs	<input type="checkbox"/>	<input type="checkbox"/>
	<i>Ongoing constipation requires physician’s attention</i>	<input type="checkbox"/>	<input type="checkbox"/>
4.	DIARRHEA		
	Imodium – give ii caplets stat then I caplet after each bowel movement to a maximum of 8 tablets a day	<input type="checkbox"/>	<input type="checkbox"/>
5.	HYPOGLYCEMIC REACTION		
	If unconscious: Call ambulance and glucagon syrup p.o.	<input type="checkbox"/>	<input type="checkbox"/>
	If Conscious: Treat with 15 grams of carbohydrates (3-4 glucose tablets) Regular soda 4-6 oz (non-diet) Low non fat milk – 8 oz Apple/Orange juice	<input type="checkbox"/>	<input type="checkbox"/>



6. <b>INDIGESTION</b>	YES	NO
Antacid – 10-20 mls between meals & bedtime. Do not exceed 80 mls in 24 hr period.	<input type="checkbox"/>	<input type="checkbox"/>
If these symptoms occur daily or several times a day and especially at night, then there could be a more serious problem. Please advise nurses.	<input type="checkbox"/>	<input type="checkbox"/>
7. <b>NAUSEA &amp; VOMITING</b>		
Natural source Gravol available as chewable lozenge or Natural Source Chewable tablets 2 tablets every 4 hours, 1 – 3 times daily, not to exceed 6 tablets per day.		
8. <b>Pain, Headache, Muscle, Joints</b>		
Acetaminophen 325 mg iii q 4h prn (max of 12 tablets in 24 hours.)		
A535 Pain relieving rub cream. Do not use more than 3-4 times daily. If condition worsens or persists more than 7 days, please advise nurses.		
9. <b>Influenza Vaccine –</b>		
Administered by Aspen Health Community Nurse		
10 <b>Urine Screening Test</b>		
Use routine requisition form. See screening test section, all categories are to be checked with the exception of UTCA tricyclic antidepressant.		

Medications listed are approved for immediate use when physician is not readily available. Doses administered are entered on physician order sheet as “Per Standing Order”. Doses given are charted on the Medication Administration Record. Standing orders are reviewed and reauthorized by physician annually.

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

