

570 of 699
DEPARTMENT OF HEALTH
HOMES FOR SPECIAL CARE PROGRAMME

Form 6

PATIENT EVALUATION FORM: NURSING RESIDENTIAL

Name: [Redacted] Name & Address of Home: Sunbeam Home, 2749

C.B.#: [Redacted] Kingsway Dr., KITCHENER, ONTARIO

Address prior to admission to OH or OHS: _____

Date & Place of Birth: [Redacted] TORONTO Religion: Protestant Sex: male

Marital Status: single Height: 52 ins. Weight: 69 lbs. Languages Spoken: -

S.I.#: _____ O.H.S.C.#: [Redacted] OHSIP #: [Redacted] FBA#: _____

Estate Supervision: The Public Trustee of Ont. Ref: _____
Private - Ref: _____

Caution Sheet Information: _____

Next-of-kin: C.A.S. Relationship: Guardian

Address: 33 Charles St. EAST. TORONTO 5, Telephone: WA-44646

Referring Hospital: _____ Date of Placement: Aug. 12/65.

1. SPEECH
 A. Rational: Always _____ Usually _____ Seldom _____ Never
 B. Voice: Loud _____ Moderate _____ Soft _____ Mute
 C. Conversation: Initiates _____ Passive _____ Polite _____ Profane _____

2. MEMORY
 A. Past events: Good _____ Poor ? Partial _____ Unable _____
 B. Recent events: Good _____ Poor _____ Partial _____ Unable _____
 C. Recognition: Self _____ Family _____ Others _____ Unable _____
 D. Orientation: Time _____ Place _____ Person _____ Unable _____

3. SOCIAL ADJUSTMENT
 A. Behavior: Friendly Reserved _____ Withdrawn Hostile _____
 B. Irritable or Cross: Often _____ Seldom _____ Never _____
 C. Demands Attention: Often _____ Seldom _____ Never _____
 D. Complains: Often _____ Seldom _____ Never _____
 E. Responses: Sociable ^{AT} _{TIMES} Unsociable _____ Dominates _____ Interferes _____

Remarks: _____

4. INTERESTS; HOBBIES, AND SKILLS
 A. Household (specify): None.
 B. Helping Others: _____
 C. Enjoys: Reading _____ Singing _____ TV/Radio _____ Music _____
 Writing _____ Games _____ Parties _____ Crafts _____
 Other(s): _____

5. PSYCHOLOGICAL STATUS
 A. Delusional: Always _____ Usually _____ Seldom _____ Never
 B. Depressed: Always _____ Usually _____ Seldom _____ Never
 C. Noisy: Always _____ Usually _____ Seldom _____ Never
 D. Aggressive or Belligerent: Often _____ Seldom _____ Never
 E. Mannerism: Overactive _____ Active Languid _____ Inactive _____

Revised June, 1969.

6. CHARACTERISTIC BEHAVIOUR

a. Bathing Enjoys Resists _____ Self _____ With Help _____
 b. Grooming Enjoys Resists SOMETIMES Self _____ Unable _____
 c. Sleeping Good Poor _____ Restless _____ Prowls _____
 Sedation needed: Regularly _____ At times _____ Never
 d. Toileting Self _____ If reminded _____ If helped SOMETIMES Continent _____
 Wets Soils Night toileting needed _____
 e. Dress Self _____ If helped _____ Helpless _____ Bed Clothes _____
 Careless _____ Removes _____ Destroys _____ (only)
 Fastidious _____ Remarks, if any _____
 f. Habits Smoking: Extreme _____ Moderate _____ Never
 Sexual Interest: Often _____ Seldom _____ Never
 Self Exposure: Yes _____ No _____ Spitting
 Collecting: Often _____ Seldom _____ Never
 Pilfering: Often _____ Seldom _____ Never
 Strong Prejudices (Persons or things): _____ NONE

7. FEEDING

a. Self At Table Tray _____ Tidy _____ Untidy _____
 b. Needs Encouragement _____ Coaxing _____ Help _____ Spoonfed _____
 c. Diet Regular Soft _____ Saltfree _____ Diabetic _____
 Special (Specify) _____
 d. Food Likes ALL FOODS Dislikes _____
 Enjoys _____ Overeats _____ Rejects _____ Slow _____
 Remarks, if any (Allergies?) NONE

8. MOBILITY

a. Walks Alone Feebly _____ With help _____ Unable _____
 b. Aids Used Wheelchair _____ Walker _____ Cane _____ Crutches _____
 c. Tendency to: Abscond _____ Wander SOMETIMES Sit only _____
 Remarks, if any _____

9. DAILY ROUTINE

a. Usually wakes at 6:30 AM
 b. Mood Cheerful Angry _____ Passive _____
 c. Most Active Morning _____ Afternoon DAY Evening _____
 d. Rest Period Morning _____ Afternoon _____ Best without _____
 Usual Toilet Times 9-4-14 AM _____ PM _____ AM (Nighttime)

10. RECOMMENDATIONS

(Suggestions for daily care, peculiarities to be observed, other than stated above)

Date _____

Supervisor or Senior Nurse. Ward _____

RE:

Name of Patient

11. MEDICAL REPORT AND DISCHARGE SUMMARY

- a. Diagnosis (Primary) Severe Mental Retardation
- b. Diagnosis (Secondary) _____
- c. Frequent Complaints _____
- d. Intercurrent Conditions Very occasional upper respiratory infection

Functional Disabilities: (Indicate item and specify below)

- a. Sight Good Partial _____ Glasses _____ Blind _____
- b. Hearing Good Partial _____ H.Aid _____ Deaf _____
- c. Teeth Good Defective _____ Dentures _____ None _____

Systemic Conditions: (Indicate item and specify below)

- Seizures _____ Dysphagia _____ Dysarthria _____ Skin Occasional eruptions
- Haemorrhoids _____ Polyuria _____ Diabetes _____ Aphasia _____ Dysrulia _____
- Emphysema _____ Cardiac Failure _____ Arthritis _____ Dyspnoea _____ Hernia _____
- Neurological deficit _____

Remarks: _____

Summary of Past Medical History: (Ailments, Injuries or Operations of significance)

None significant

Blood Pressure 98/78 Phys. Exam. 3 Mos. N.A.D. 6 Mos. N.A.D. Annually N.A.D.
 Radiology (Chest) Film clear Date 1972
 Urinalysis Sp.Gr. N.A.D. Reac. _____ Alb. _____ Sug/Act _____ Micro _____
 Haematology Hgb _____ %W.B.C. _____ VDRL _____

Chest X-Ray: Date _____ Findings _____

Dental Treatment: NONE
 Fillings Completed _____
 Periodontal Treatment Completed _____
 Prosthesis provided _____

Regular Medication: None

Medication	Dose and Frequency	Date started

Special Recommendations: (e.g. care, allergies, reactions, alcoholism, etc.) None

Date Apr 21/73

Signature Staff Physician _____

743-1486
Name and Telephone Number