[redacted]

ANNUAL MEDICAL ASSESSMENT - O.H.S. ORILLIA

Name [redacted] # [redacted] Unit Aud Date 1974

Admitted 3-12-73. Admission I.Q. Birth Date [redacted] 61

Height: 137 Weight: 29.7 Date of Last Assessment: 1973.

Eyes: Nyg.

Ears: Nyg. Nose: Nyg

Teeth, Throat & Palate: Nyg.

Thyroid: Nyg.

Heart: Nyg. B.P. 110/70

Lungs: Nyg

Breasts: Nyg Hernia: Nil

Abdomen: Nyg.

G.U. System: Nyg

Menstrual History: N/A

Skin: Nyg

Skeleton: Nyg Head:

Nervous System: Nyg.

Urine: SP.G. Alb. Sugar: MICRO:

Blood: Hgb: WBC: Neutros: (bands, Juv, Polys %)

% Lymphos: Monos: Eosinos:

R.B.C.'s:

V.D.R.L. TBC Tests: Diseases:

Medication: 0

Last Psychological Assessment:
Date: I.Q.: M.A.:

Etiology: SMR - Autism

Diagnosis:

A.A.M.D. I.C.D. (8)

Remarks: T.T. to routine
"Rumo"
does not dress himself.
Self care & sensory program.

[redacted]

ANNUAL MEDIC[redacted] ORILLIA:

Name: [redacted] C.B.# [redacted] Unit: Awa... Date: Apr 1975

Admitted: 3-12-73. Admission I.Q.: Birth Date: [redacted]/61

Height: Weight: Date of Last Assessment: 1974

Eyes: Neg.

Ears: Neg

Nose: Neg.

Teeth, Throat & Palate: Neg.

Thyroid: Neg.

B.P.: 120/70

Heart: Neg.

Lungs: Clear

Abdomen/Hernia/Etc.: Neg

G.U. System: Neg

Menstrual History: n/a

Skin: Neg.

Head: Neg.

Skeleton: Neg.

Nervous System: Neg

Urine: SP.G.: Alb: Sugar: Micro:

Blood: Hgb: WBC: Neutros: Lympho:

Monos: Eosinos: Basos:

R.B.C.'s: V.D.R.L.: T.B.C. TESTS:

Diseases:

Medication: Ritalin 30 mg bid.

Last Psychological Assessment:

Date: I.Q. M.A.

Etiology: SMR. Autism

Diagnosis:

Remarks: No speech - Runs. T/T to routine

[redacted]

*lm

[redacted]

ANNUAL MEDICAL ASSESSMENT - H.R.C., ORILLIA:

Name: [redacted] .. [redacted] C.B.# [redacted] Unit: Aux.?... Date: May 76

Admitted: 3-12-73 Admission I.Q.: Birth Date: [redacted] 61

Height: Weight: Date of Last Assessment: 1975

Eyes: Ng.

Ears: Ng. Nose: Ng.

Teeth, Throat & Palate: Ng

Thyroid: Ng. B.P.:

Heart: No murmur heard.

Lungs: Clear to B.A.

Abdomen/Hernia/Etc.: Ng.

G.U. System: Ng.

Menstrual History: N/A

Skin: Ng. Head:

Skeleton: Ng.

Nervous System: Ng

Urine:	SP.G.:	Alb:	Sugar:	Micro:
Blood:	Hgb:	WBC:	Neutros:	Lympho:
	Monos:	Eosinos:	Basos:	

R.B.C.'s: V.D.R.L.: T.B.C. TESTS:

Diseases:

Medication: Multi Vits c̄ C. Phenob 30 mgs dic

Last Psychological Assessment:

Date: I.Q. M.A.

Etiology:

Diagnosis: SMR - Autism

[redacted]

Remarks: No speech
TT to routine

*lm

[redacted]

ORIGINAL FILE

ANNUAL MEDICAL ASSESSMENT - H.R.C. ORILLIA

Name: [redacted] C.B.# [redacted] Unit: Terr.7 Date: Nov.15/77

Admitted: 3/12/73 Admission I.Q.: Severe Birth Date: [redacted]61

Height: 162 cm. Weight: 44 kg. Date of last Assessment: March/76

Eyes: PERL, externally healthy.

Ears: drums intact. **Nose:** free.

Teeth, Throat & Palate: not seen, did not cooperate.

Thyroid: not enlarged. **B.P.:** 120/68

Heart: PR: 88/min., regular, no murmurs.

Lungs: clear for auscultation.

Abdomen/Hernia/Etc.: soft, no tenderness or masses, no organomegaly.

G.U. System: normal male, not circumcised, both testicles descended.

Menstrual History: N/A **Head:** Circ: 54.2 cm

Skin: clean.

Skeleton: no abnormalities.

Nervous System: tendon reflexes brisk, equal, toes downgoing bilaterally, no speech.

Urine: SP.G.: Alb: neg. Sugar: neg. Micro: normal.

Blood: Hgb: 13.4gm WBC: 10,100 Neutros: 68% Lympho: 28% Monos: 2% Eo: 2% Baso:

R.B.C.'s: appear normal. **V.D.R.L.:** Dec.4/73 **TBC Tests:**

Diseases: non-reactive. Skin test-neg.Sept/77

no serious illnesses in 1976.

Medication: none.

Last Psychological Assessment
Date Sept.3/75 I.Q.: Sev. M.A.: 2-5

Etiology: Heredity.

Incompetency Status:
(Developmental Services Act, 1974)

Diagnosis: 313.~~99~~ Severe mental retardation due to other biolog. conditions
No speech. (parents & 6 other siblings)

REMARKS:
Hepatitis B Antigen positive.
Feb. 12/74 - Consultation with Dr. [redacted] - Autistic.

[redacted]

.....

[redacted] M.D.
Staff Physician.

/Mc

[redacted]

ANNUAL MEDICAL ASSESSMENT - H.R.C. ORILLIA

ORIGINAL FILE

NAME: [redacted] C.B.# [redacted] UNIT: TV7 DATE: Nov. 14/78

DATE OF ADMISSION: 3/12/73 ADMISSION I.Q.Sev SEX: M. BIRTH DATE [redacted]61

HEIGHT: 164 cms. WEIGHT: 48.3 kg. DATE OF LAST ASSESSMENT: Nov. 15/77

EYES: 19/06/78 far-sightedness & light sensitive, no Rx. NOSE: free.

EARS: PERL.
Nov. 8/77 adequate hearing for speech, drums intact.

TEETH, THROAT & PALATE: throat not seen, did not cooperate. B.P.: 130/80

THYROID: not enlarged.

HEART: PR: 82/min., regular, no murmurs.

BREASTS: N/A

LUNGS: Clear for auscultation.

ABDOMEN/HERNIA/ETC.: soft, no tenderness or masses, no organomegaly.

G.U. SYSTEM: normal male, both testicles descended.

MENSTRUAL HISTORY: N/A HEAD: circ: 55.8 cm.

SKIN: surgical scar over L. hip, skin clean.

SKELETON: no abnormalities.

NERVOUS SYSTEM: tendon reflexes brisk , equal, toes downgoing bilaterally, no speech.

URINE: S.P.G.: ALB.: neg. SUGAR: neg. MICRO: normal

BLOOD: HGB. 13/5 gms. WBC: 9500 NEUTROS: 66% LYMPHO: 31% MONOS: %

R.B.C.'s: appear normal V.D.R.L.: Dec. 4/73 non-reactive. EOSINOS: 2 % BASOS: 1 %

DISEASES:
February 1978 first grand mal seizure.
Jan/78 fracture of L. hip. Pin & plate fixation.
July/78 choking episode on food.

TBC Tests: Sept/78
Skin test: neg.

MEDICATION: Mysoline 250 mg. h.s.
Nozinan 5 mg. h.s.

LAST PSYCHOLOGICAL ASSESSMENT:
Date: Jan. 13/78. Q. Pro. M.A. 1-6

ETIOLOGY: Heredity

INCOMPETENCY STATUS: to continue
(Developmental Services Act 1974)

DIAGNOSIS:
314.81 Profound mental retardation due to other biolog. conditions
No speech. (parents & 6 other siblings).

REMARKS: Epileptic (2 seizures in 1978 so far, not to be known epileptic previously)
Hepatitis B Antigen +
Jan. 18/78 Pin & Plate #(L) hip - Dr. [redacted]
July 1978 Observation of convulsive disorder.

E.E.G: normal sedated record.

/Mc

[redacted] M.D.
Staff Physician.

ORIGINAL FILE

ANNUAL MEDICAL ASSESSMENT - H.R.C. ORILLIA

NAME: [redacted] C.B.# [redacted] UNIT: TV7 DATE: Nov. 2/79

DATE OF ADMISSION: 8/12/73 ADMISSION I.Q. Sev. SEX: M. BIRTH DATE: [redacted]61

HEIGHT: 170 cms. WEIGHT: 50 kg. DATE OF LAST ASSESSMENT: Nov. 14/78

EYES: 19/06/78 far-sightedness. No Rx.

NOSE: free

EARS: Nov. 8/77 adequate hearing, wax bilat.

TEETH, THROAT & PALATE: will not permit examination, did'nt open mouth. B.P.: 110/70

THYROID: not enlarged.

HEART: PR: 76/min., regular, no murmurs.

BREASTS: N/A

LUNGS: clear for auscultation.

ABDOMEN/HERNIA/ETC.: soft, no tenderness or masses, no organomegaly.

G.U. SYSTEM: normal male, both testicles descended.

MENSTRUAL HISTORY: N/A HEAD: circ: 55.8 cm.

SKIN: surgical scar over L. hip, skin clean.

SKELETON: no abnormalities.

NERVOUS SYSTEM: tendon reflexes brisk, equal, toes downgoing bilat, no speech.

URINE: S.P.G.: ALB: neg. SUGAR: neg. MICRO: normal

BLOOD: HGB. 14.1 gms. WBC: 5900 NEUTROS: 61 % LYMPHO: 31 % MONOS: 1 %

R.B.C.'s: appear normal. V.D.R.L.: Dec. 4/73 non-reactive. EOSINOS: 7 % BASOS: % Nov. 27/79

DISEASES:

Jan/78 pin & plate fixation for fracture of L. hip/Skin test: neg.

July/78 choking episode on food. No illnesses in 1979.

TBC TESTS: Sept/79

MEDICATION:

Mysoline 25o mg. q.h.s.

LAST PSYCHOLOGICAL ASSESSMENT:

Date: Jan. 2/79 I.Q. Pro. M.A. 1-6

INCOMPETENCY STATUS: to continue.
(Developmental Service Act 1974)

ETIOLOGY: Heredity.

DIAGNOSIS:

Profound mental retardation due to biolog. condition (parents & 6 other siblings-see file).

No speech.

REMARKS: Epileptic (2 seizures in 1978, none in 1979 so far)
Hep. B. Antigen Positive.
In Feb/78 first grand mal seizure, not known to be epileptic previously.

/Mc

[redacted] M.D.
Staff Physician

ANNUAL MEDICAL ASSESSMENT - H.R.C. ORILLIA

NAME: [redacted] C.B.# [redacted] UNIT: TV4 DATE: Nov. 7/80

DATE OF ADMISSION: 3/12/73 ADMISSION I.Q.Sev. SEX: M. BIRTH DATE [redacted]61

HEIGHT: 169 cms. WEIGHT: 52.6 kg. DATE OF LAST ASSESSMENT: Nov. 2/79

EYES: May 28/80: highly hyperopic, astigmatism, non-strabismic, no Rx. NOSE: free.

EARS: R. ear wax, L ear drum intact.

TEETH, THROAT & PALATE: Throat not properly seen, will not permit examination. B.P.: 104/58

THYROID: not enlarged.

HEART: PR: 88/min., regular, no murmurs.

BREASTS: N/A

LUNGS: clear for auscultation.

ABDOMEN/HERNIA/ETC.: soft, no tenderness or masses, no organomegaly.

G.U. SYSTEM: normal male, both testicles descended.

MENSTRUAL HISTORY: N/A HEAD: cir: 56 cm.

SKIN: surgical scar over L. hip, skin clean.

SKELETON: no abnormalities.

NERVOUS SYSTEM: tendon reflexes brisk & equal, toes downgoing bilaterally, no speech.

URINE: S.P.G.: ALB: neg. SUGAR: neg. MICRO: occ. pus Nov.27/80

BLOOD: HGB.: 15.0gms. WBC: 10,700 NEUTROS: 65 % LYMPHO: 25 % MONOS: 2 %

R.B.C.'s: appear normal. V.D.R.L.: Dec. 4/73 non-reactive. EOSINOS: 7 % BASOS: 1 %

DISEASES: No illnesses in past year. TBC TESTS: Sept/80 Skin test: neg.

MEDICATION: Phenobarb 30 mg. q.h.s.

LAST PSYCHOLOGICAL ASSESSMENT: Date: Jan. 2/79 I.Q. Pro. M.A. 1-6

INCOMPETENCY STATUS: to continue. (Developmental Service Act 1974)

ETIOLOGY: Heredity.

DIAGNOSIS: Profound mental retardation, due to biological condition (parents & 6 other siblings - see file)

No speech.

REMARKS:

Epileptic (No seizures in 1979, no seizures in 1980 so far).
Hepatitis B antigen positive.

/Mc

[redacted] M.D.
Staff Physician

ORIGINAL - FILE

ANNUAL MEDICAL ASSESSMENT - H.R.C. ORILLIA

NAME: [redacted] C.B.# [redacted] UNIT: T.V.1 DATE: Nov. 4/81

DATE OF ADMISSION: 3/12/73 ADMISSION I.Q. Sev. SEX: M BIRTH DATE: [redacted]61

HEIGHT: 171 cms. WEIGHT: 51.3 kg. DATE OF LAST ASSESSMENT: Nov. 7/80

EYES: July 6/81 astigmatic both eyes. No Rx. NOSE: free.

EARS: Nov. 8/77 adequate hearing, lt. ear wax+ rt. ear.

TEETH, THROAT & PALATE: will not open his mouth. B.P. 110/60

THYROID: not enlarged.

HEART: PR 82/min., regular, no murmurs.

BREASTS: neg.

LUNGS: clear for auscultation.

ABDOMEN/HERNIA/ETC.: soft, no tenderness or masses, no organomegaly.

G.U. SYSTEM: normal male development, both testicles descended.

MENSTRUAL HISTORY: N/A HEAD: Circ. 55.7 cm.

SKIN: surgical scar over lt. hip, no rash or bruises.

SKELETON: no abnormality.

NERVOUS SYSTEM: tendon reflexes brisk, equal, toes downgoing bilaterally, no speech.

URINE: S.P.G.: ALB: neg. SUGAR: neg. MICRO: normal.

BLOOD:	HGB.: 14.9 gms.	WBC: 10,800	NEUTROS: 61%	LYMPHO: 31%	MONOS: 1%	Dec. 4/81
R.B.C.'s:		V.D.R.L.: Dec. 4/73 non-reactive	EOSINOS: 5 %	BASOS: 2 %	Dec. 7/81

DISEASES:

no illnesses in past year.

TBC TESTS:

MEDICATION:

Phenobarb 30 mg. q.h.s.

LAST PSYCHOLOGICAL ASSESSMENT:

Date: Jan. 2/79 I.Q. Prof M.A. 1-6

INCOMPETENCY STATUS: to continue

(Developmental Service Act 1974)

ETIOLOGY: Heredity.

DIAGNOSIS:

Profound mental retardation due to heredity (biological conditions.)
No speech.
Epileptic (free of seizures)

REMARKS:

OK/sh

[redacted], M[redacted]

Staff Physician

ANNUAL MEDICAL ASSESSMENT - H.R.C. ORILLIA

ORIGINAL - FILE

NAME: [redacted] C.B.# [redacted] UNIT: T.V.1 DATE: November 3, 1982

DATE OF ADMISSION: 3/12/73 ADMISSION I.Q.: Sev. SEX: M BIRTHDATE: [redacted]51

HEIGHT: 170.5 cms. WEIGHT: 54kg. DATE OF LAST ASSESSMENT: Nov. 4/81

HEAD & NECK: circ. 55.8 cm.

EYES: July/81 astigmatism both eyes, no Rx.

EARS & NOSE: Nov. 8/77 normal hearing, wax bilat.

TEETH, THROAT & PALATE: will not permit examination.

THYROID: not enlarged.

HEART/B.P.: 120/68, P.R.: 78/min., regular, no murmurs.

BREASTS: neg.

LUNGS: clear for auscultation.

ABDOMEN/HERNIA/RECTAL/ETC.: soft, no tenderness or masses, no organomegaly.

G.U. SYSTEM: normal male, both testicles descended.

MENSTRUAL HISTORY: N/A

SKIN: surgical scar over lt. hip, free of rash or bruises.

SKELETON: no abnormality.

NERVOUS SYSTEM: tendon reflexes brisk on lower extremities, will not permit examination on upper extremities, no speech.

URINE: S.P.G.: ALB: neg. SUGAR: neg. MICRO: normal

BLOOD: HGB.: 13.8 gms. WBC: 5900 NEUTROS: 56 % LYMPHO: 26 % MONOS: 5 % Nov. 9/82

R.B.C.'s: appear normal. V.D.R.L.: Dec./73 non-reactive EOSINOS: 11 % BASOS: 2 %

DISEASES:

No illnesses in past year.

TBC TESTS:

Skin test - neg. Oct./82

MEDICATION:

Phenobarb 30 mg. q.h.s.
Double diet, Meritene 1 can q.h.s.
Nozinan 10 mg. t.i.d.

LAST PSYCHOLOGICAL ASSESSMENT:

Date: 2/1/79 I.Q. Prof. M.A. 1-6

DIAGNOSES

M.R. & ETIOLOGY: Profound mental retardation due to biological conditions (heredity).

OTHER: No speech
Epileptic (free of seizures)
Disturbed behaviour.

INCOMPETENCY STATUS: to continue (Developmental Services Act 1974)

DMPA STATUS: 0

REMARKS: Will not co-operate.

OK/sh

[redacted] M.D. [redacted]

STAFF PHYSICIAN

Use reverse if necessary.

[redacted]

ANNUAL MEDICAL ASSESSMENT - R.C. ORILLIA ORIGINAL = FILE

NAME: [redacted] C.B.# [redacted] UNIT: TV 1 DATE: Nov. 3/83

DATE OF ADMISSION: Dec. 3/73 ADMISSION I.Q.: Sev. SEX: M BIRTHDATE: [redacted]61

HEIGHT: 172 cms. WEIGHT: 56.3 kg. DATE OF LAST ASSESSMENT: November 3, 1982

HEAD & NECK: Circum: 56 cm

EYES: Jan. 19, 1983: eyes healthy - No Rx.

EARS & NOSE: Nov. 8/77: Normal hearing. Wax bilat.

TEETH, THROAT & PALATE: L. Upper lateral incisor missing, throat not seen (will not open mouth).

THYROID: Not enlarged.

HEART/B.P.: 118/68. P.R.: 88/min, regular, no murmurs.

BREASTS: Neg.

LUNGS: Clear to auscultation.

ABDOMEN/HERNIA/RECTAL/ETC.: Soft, no tenderness or masses, no organomegaly.

G.U. SYSTEM: Normal male, both testicles descended.

MENSTRUAL HISTORY: N/A

SKIN: Surgical scar over L. hip (1978 pin + plate) no rash or bruises.

SKELETON: No abnormality.

NERVOUS SYSTEM: Tendon reflexes difficult to obtain, brisk on lower extremities, toes ↓ bilat., no speech.

URINE: S.P.G.: ALB: neg. SUGAR: neg. MICRO: normal

BLOOD: HGB.: 13.3 gms. WBC: 5.1 NEUTROS: .65 % LYMPHO: .25 % MONOS: .02 %

R.B.C.'s: normal V.D.R.L.: Dec./73 non-reactive EOSINOS: .04 % BASOS: .01 %

DISEASES:

No illnesses in past year.

TBC TESTS:

Skin test - neg. Aug./83

MEDICATION: Phenobarb 30 mg q.h.s.; Nozinan 10 mg ~~t~~.i.d.; Double diet and 1 can of Meritene daily

LAST PSYCHOLOGICAL ASSESSMENT:

Date: Jan. 2/79 I.Q. Prof. M.A. 1-6

DIAGNOSES M.R. & ETIOLOGY: Profound mental retardation due to biological conditions (heredity)

INCOMPETENCY STATUS: to continue (Developmental Services Act 1974)

DMPA STATUS: n/a

OTHER: No speech.
Epileptic (No seizures in past year).
Behaviour distrubed at times, improved.

REMARKS:

[redacted] M.D.

STAFF PHYSICIAN

Use reverse if necessary.

/sm

ANNUAL MEDICAL ASSESSMENT - H.R.C. ORILLIA

NAME: [redacted] C.B.# [redacted] UNIT: TV 1 DATE: Oct. 4/84

DATE OF ADMISSION: Dec. 3/73 ADMISSION IQ: Sev. SEX: M BIRTHDATE: [redacted]/61

HEIGHT: 170.5 cms. WEIGHT: 55.8 kg. DATE OF LAST ASSESSMENT: Nov. 3/83

HEAD & NECK Normal

EYES: 6/9/84 hyperopic - no glasses given PERl

EARS & NOSE: Hearing within normal limits. Cerumen in canals. Nasal discharge.

TEETH, THROAT & PALATE: Upper incisor missing.

THYROID: not enlarged.

HEART/B.P.: B.P. 118/80. Pulse 76 - reg. No murmurs.

BREASTS: Normal

LUNGS: Clear to P & A.

ABDOMEN/HERNIA/RECTAL/ETC.: No organomegaly.

G.U. SYSTEM: Normal

MENSTRUAL HISTORY: N/A

SKIN: Clear

SKELETON: No deformities.

NERVOUS SYSTEM: Reflexes brisk. No Babinski's or clonus.

URINE: ALB: neg. SUGAR: neg. MICRO: OTHER: normal Oct./84

BLOOD: HGB: 14.1 gms. WBC: 06.2 NEUTROS: .42 % LYMPHO: .33 % MONOS: .06 %

RBC's: 5.13 normal VDRL: 1973 EOSINOS: .10 % BASOS: .02 %

DISEASES: non-reactive. TBC TESTS:

Skin test.

LAST PSYCHOLOGICAL ASSESSMENT:

Date: Jan./79 IQ Prof. M.A. 1-6

MEDICATION:

INCOMPETENCY STATUS: Incomp.

DMPA STATUS:

MEDICAL CAUTION FORM REVIEWED X

DIAGNOSES - M.R. LEVEL & ETIOLOGY

Profound Mental Retardation due to biological conditions (heredity)

OTHER: Epileptic.

REMARKS:

[redacted] M.D.

:mp

RR 9 STAFF PHYSICIAN

[redacted]

ANNUAL MEDICAL ASSESSMENT - H.R.C. ORILLIA

NAME: [redacted] C.B.# [redacted] UNIT: Cott. 10 DATE: Dec. 4/85

DATE OF ADMISSION: Dec. 3/73 ADMISSION IQ: Severe SEX: M BIRTHDATE: [redacted]51

HEIGHT: 171 cms. WEIGHT: 69 kg. DATE OF LAST ASSESSMENT: Oct. 4/84

HEAD & NECK Normal.

EYES: PERL.

EARS & NOSE: Cerumen in canals.

TEETH, THROAT & PALATE: Pharynx clear.

THYROID: Not enlarged.

HEART/B.P.: B.P. 124/70. Pulse 82 - reg. No murmurs.

BREASTS: Normal.

LUNGS: Clear to P & A.

ABDOMEN/HERNIA/RECTAL/ETC.: No organomegaly.

G.U. SYSTEM: Normal male.

MENSTRUAL HISTORY: n/a

SKIN: Surgical scar over (L) hip (pin & plate in 1978).

SKELETON: No deformities.

NERVOUS SYSTEM: Reflexes brisk. No Babinski's.

URINE: ALB: neg. SUGAR: neg. MICRO: occ. pus OTHER:

BLOOD: HGB: 14.2 gms. WBC: 6.6 NEUTROS: 74 % LYMPHO: 12 % MONOS: 04 %

RBC's: 5.09 VDRL: non-reactive EOSINOS: 02 % BASOS: %

DISEASES:

Healthy.

TBC TESTS:

Oct. '85 - neg.

LAST PSYCHOLOGICAL ASSESSMENT:

Date: Jan. '79 IQ M.A.

MEDICATION:

Phenobarb 30 mg. q.h.s.
Nozinan 10 mg. t.i.d.

INCOMPETENCY STATUS: to continue

DMPA STATUS: n/a

MEDICAL CAUTION FORM REVIEWED x

DIAGNOSES - M.R. LEVEL & ETIOLOGY

Profound Mental Retardation - unknown cause.

OTHER:

Epileptic
Heptavax B - has antibodies

REMARKS: One G.M. seizure in Apr. of '85 and one in 1984.

/lb
RR 9 (T)

[redacted].....
.D.
STAFF PHYSICIAN

ANNUAL MEDICAL ASSESSMENT - H.R.C. ORILLIA

ORIGINAL FILE

NAME: [redacted] C.B.# [redacted] UNIT: Cott. 10 DATE: Dec. 10/86

DATE OF ADMISSION: 3/12/73 ADMISSION IQ: Profound SEX: M BIRTHDATE: [redacted]61

HEIGHT: 171 cms. WEIGHT: 70.2 kg. DATE OF LAST ASSESSMENT: Nov. 3/83

HEAD & NECK: Normal.

EYES: PERL.

EARS & NOSE: Cerumen in canals.

TEETH, THROAT & PALATE: Pharynx couldn't be examined.

THYROID: Not enlarged.

HEART/B.P.: B.P. 138/68. No murmurs.

BREASTS: Normal.

LUNGS: Clear to P & A.

ABDOMEN/HERNIA/RECTAL/ETC.: No organomegaly.

G.U. SYSTEM: Normal male.

MENSTRUAL HISTORY: N/A

SKIN:
Surgical scar over (L) hip - (pin & plate in 1978)

SKELETON:
No deformities.

NERVOUS SYSTEM: Reflexes brisk. No Babinski's.

URINE: ALB: Neg. SUGAR: Neg. MICRO: Normal OTHER: Dec. 24/86

Nov. 21/86 BLOOD: HGB: 15.0 gms. WBC: 7.2 ~~NEUTROS~~: % LYMPHO: 29.5 % MONOS: 8.6 %
GRAN.: 61.9%

RBC's: normal VDRL: non-reactive. EOSINOS: % BASOS: %

DISEASES:
Healthy.

TBC TESTS: Sept. '86
Negative.

LATEST PSYCHOLOGICAL ASSESSMENT

DATE: Feb. 1974
I.Q.: 20 M.A.:

INCOMPETENCY STATUS: Incompetent

DMPA STATUS: n/a

MEDICAL CAUTION FORM REVIEWED: ~~yes~~

MEDICATION:
Nozinan 10 mg. t.i.d.
Phenobarb 30 mg. q.h.s.
Double regular diet.

DIAGNOSES - M.R. LEVEL & ETIOLOGY
Mental Retardation due to hereditary biological conditions.

OTHER:
Epileptic (seizure free)
Has had Heptavax B
No speech.

REMARKS:

[redacted]
[redacted], M.D.
STAFF PHYSICIAN

RR 9(T) /1b

ORIGINAL FILE

ANNUAL MEDICAL ASSESSMENT - HRC ORILLIA

NAME: [redacted] CB#: [redacted] LOCATION: Cott. 10 DATE: 1987 12 24

DATE OF ADMISSION: 1973 12 03 BIRTHDATE: 1961 [redacted] SEX: M

HEIGHT: WEIGHT: DATE OF LAST ASSESSMENT: 1986 12 10

HEAD & NECK:

EYES: P.E.R.L.

EARS & NOSE: Cerumen in (L) canal. (R) drum normal.

TEETH, THROAT & PALATE: Pharynx clear.

THYROID: Not enlarged or nodular.

HEART/B.P.: B.P. 138/72. No murmurs. P.72-reg.

BREASTS: Normal.

LUNGS: Clear to P. & A.

ABDOMEN/HERNIA/RECTAL/ETC.: No organomegaly.

G.U. SYSTEM: Normal male.

MENSTRUAL HISTORY: N/A.

SKIN: Scar (L) hip - had pin and plate inserted in 1978.

SKELETON: No deformities.

NERVOUS SYSTEM: Reflexes brisk. No Babinski's or clonus.

URINE: ALB: Neg. SUGAR: Neg. MICRO: Normal.

BLOOD: HGB: 147 gms. WBC: 5.3 LYMPHO: 36.0% MONOS: 5.9% RBC's: 4.89

OTHER LAB TESTS: LAST PSYCHOLOGICAL ASSESSMENT: Jan./79 - M.A. 1-6

TBC TESTS: Sept. 86 - neg.

INCOMPETENCY STATUS: To continue. MEDICAL CAUTION FORM REVIEWED: Yes

DISEASES: Epileptic.

MEDICATION: Nozinan 10 mg. q.a.m.
Nozinan 5 mg. q.h.s.
Phenobarb 30 mg. q.h.s.

DIAGNOSES: Mental retardation due to heredity and biological conditions.

REMARKS: Antibodies to Hep. B.
No seizures since 1985.

[redacted] M.D.,
STAFF PHYSICIAN.

/tm

ORIGINAL FILE

ANNUAL MEDICAL ASSESSMENT - HRC ORILLIA

NAME: [redacted] CB#: [redacted] LOCATION: Cottage 10 DATE: Nov. 01/88

DATE OF ADMISSION: Dec. 03/73 BIRTHDATE: [redacted]51 SEX: M

HEIGHT: 170 cm. WEIGHT: 68.5 kg. DATE OF LAST ASSESSMENT: Dec. 24/87

HEAD & NECK:

EYES: P.E.R.L.

EARS & NOSE: Cerumen in (L) canal. (R) drum normal.

TEETH, THROAT & PALATE: Pharynx clear

THYROID: Not enlarged or nodular

HEART/B.P.: 122/64 Pulse - 84

BREASTS: Normal

LUNGS: Clear to P & A

ABDOMEN/HERNIA/RECTAL/ETC.: No organomegaly

G.U. SYSTEM: Testicles descended

MENSTRUAL HISTORY: N/A

SKIN: Scar (L) hip - had pin and plate inserted in 1978

SKELETON: No deformities

NERVOUS SYSTEM: Reflexes brisk. No Babinski's or clonus.

URINE: ALB: Negative SUGAR: Negative MICRO: Normal

BLOOD: HGB: 14.7 WBC: 5.5

OTHER LAB TESTS:

TBC TESTS: Aug. 23/88 - Negative

INCOMPETENCY STATUS: Incompetent MEDICAL CAUTION FORM REVIEWED: Yes

DISEASES: March '88 - Contact with pinworms - treated
Healthy

MEDICATION: Nozinan 10 mg. q.a.m.
Nozinan 5 mg. q.h.s.
Phenobarb 30 mg. q.h.s.

DIAGNOSES: Mental Retardation due to heredity and biological conditions

REMARKS: Antibodies to Hep. B
No seizure since 1985

[redacted] M.D.,
Staff Physician.

/lf

cc: Health Nurse (2)

ANNUAL MEDICAL ASSESSMENT - HRC ORILLIA

NAME: [redacted] CB#: [redacted] LOCATION: Cottage 10 DATE: 1990 01 25

DATE OF ADMISSION: 1973 02 03 BIRTHDATE: 1961 [redacted] SEX: M

HEIGHT: 170 cm. WEIGHT: 64.8 kg. DATE OF LAST ASSESSMENT: 1988 11 01

HEAD & NECK:

EYES: P.E.R.L.

EARS & NOSE: Cerumen in canals.

TEETH, THROAT & PALATE: Pharynx clear, no adenopathy.

THYROID: Not enlarged or nodular.

HEART/B.P.: B.P.: 160/80 No murmurs.

BREASTS: Normal

LUNGS: Clear to P & A

ABDOMEN/HERNIA/RECTAL/ETC.: No organomegaly.

G.U. SYSTEM: Normal male.

MENSTRUAL HISTORY: N/A

SKIN: Clear.

SKELETON: No deformities.

NERVOUS SYSTEM: Reflexes brisk. No Babinski's.

URINE: ALB: Neg. SUGAR: Neg. MICRO: Normal March 12, 1990

BLOOD: HGB: 148 WBC: 12.6 February 08, 1990

OTHER LAB TESTS:

TBC TESTS:

INCOMPETENCY STATUS: Inc. MEDICAL CAUTION FORM REVIEWED: Yes

DISEASES: 1) Behaviour Problem.
2) Seizures recurred (6) after having none for years.

MEDICATION: See medication profile.

DIAGNOSES: 1) Mental Retardation - cause unknown.
2) Epiletpic.
3) Behaviour related to stress.

REMARKS:

[redacted] M.D.,
Staff Physician.

/lf

cc: Health Nurse

HURONIA REGIONAL CENTRE, ORILLIA

MEDICAL ASSESSMENT - ANNUAL UPDATE

NAME: [redacted] DATE: March 25, 1991

LOCATION: Cottage 10 CASEBOOK #: [redacted]

Ht. 170 cm. Wt.: 67.7 kg. B.P.: 160/80 P: 76 R: 20

HGB: 148 WBC: 5.2

URIN.: Alb.: Neg. Sugar: Neg. Micro: Normal

Illnesses Since Last Assessment:

No illnesses in 1990.

Medication:

See Current Medication Profile

Diagnosis Update:

1) Developmentally Handicapped - cause unknown.
2) Generalized tonic-clonic seizures - 6 in 1990.
3) Behaviour Problem.

Comments:

Medical Caution
Form Reviewed X

[redacted] M.D.,
Staff Physician.

/lf

cc: Health Nurse

HURONIA REGIONAL CENTRE, ORILLIA

MEDICAL ASSESSMENT
ANNUAL UPDATE

NAME: [redacted]

LOCATION: Cottage 10 A

DATE: March 2, 1992

C.B.#: [redacted]

Ht.: 170.5 cm. Wt.: 75 kg. B.P.: 156/80 P: 72 R: 18

Hgb: 152 WBC: 6.2 URINE: Alb.: Neg. Sugar: Neg. Micro:

Triple Phos. +1
Calcium Oxalate +1
Amorphous Phosphates +12

Illnesses Since Last Assessment:

No illnesses in 1991.

Medication:

See Current Medication Profile

Diagnosis Update:

1. Developmentally Handicapped - cause unknown
2. Epilepsy - 2 seizures in 1991
3. No speech
4. Pin and plate (L) hip - 1978
5. Behaviour problem

Comments:

I will reduce his Nozinan - his behaviour has been acceptable.

Medical Caution
Form Reviewed X

[redacted] M.D.,
Staff Physician.

/lf

cc: ORIGINAL
WARD
HEALTH NURSE

[redacted]

ANNUAL MEDICAL ASSESSMENT - HRC ORILLIA

NAME: [redacted] CB#: [redacted] LOCATION: Cott. 10 DATE: Sept. 15, 1993

DATE OF ADMISSION: December 3, 1973 BIRTHDATE: [redacted]1961 SEX: Male

HEIGHT: 172 cm. WEIGHT: 78 kg. DATE OF LAST ASSESSMENT: March 2, 1992

HEAD & NECK: Normal.

EYES: P.E.R.L.

EARS & NOSE: Cerumen in canals.

TEETH, THROAT & PALATE: Pharynx clear.

THYROID: Not enlarged or nodular.

HEART/B.P.: B.P.: 138/88 Pulse: 78 No murmurs.

BREASTS: Normal.

LUNGS: Clear to percussion and auscultation.

ABDOMEN/HERNIA/RECTAL/ETC.: No organomegaly.

G.U. SYSTEM: Normal male.

MENSTRUAL HISTORY: N/A

SKIN: Scar from pin and plate left hip.

SKELETON: No deformities.

NERVOUS SYSTEM: Reflexes brisk. No Babinski's.

TBC TESTS: September 1992 - Negative.

INCOMPETENCY STATUS: Inc. MEDICAL CAUTION FORM REVIEWED: Yes

DISEASES: No illnesses in past year.

MEDICATION: See Medication Profile

DIAGNOSES:
1) Developmentally Handicapped - cause unknown.
2) Epilepsy - 7 seizures in 1992.
3) Behaviour problem.
4) Old fracture left hip in 1978.

REMARKS:

[redacted] M.D.,
Staff Physician.

/lf

cc: Health Nurse

ORIGINAL FILE

MEDICAL ASSESSMENT - HRC ORILLIA

NAME: [redacted] **CB#:** [redacted] **LOCATION:** Cot. 10 **DATE:** 1995 September 25

DATE OF ADMISSION: 1973 December 03 **BIRTHDATE:** 1961 [redacted] **SEX:** Male

HEIGHT: 170.5 cm. **WEIGHT:** 74.0 kg. **DATE OF LAST ASSESSMENT:** 1993 September 15

HEAD & NECK: Average.

EYES: P.E.R.L.A. Fundi grossly normal.

EARS & NOSE:
Clean. Tympanic membranes pink. Light reflex adequate.
Nose: no discharge.

TEETH, THROAT & PALATE: Teeth attended. Throat not inflamed.

THYROID: Not enlarged. No lymphadenopathy.

HEART/B.P.:
B.P.: 120/78 **PULSE:** 80 regular
S1, S2 normal. No heart murmur heard. Peripheral pulses felt. Peripheral circulation adequate.

BREASTS: N/A

LUNGS: Clear to percussion and auscultation.

ABDOMEN/HERNIA/RECTAL/ETC.:
Soft. No organomegaly and/or tenderness. Rectal examination average.

G.U. SYSTEM: Circumcised. Testicles descended.

MENSTRUAL HISTORY: N/A

SKIN: Incisional scar left hip.

SKELETON: Average development.

NERVOUS SYSTEM:
Cranial nerves intact. Deep tendon reflexes symmetrical.
Babinski downgoing.

TBC TESTS: 1994 September 20 - Negative

INCOMPETENCY STATUS: To continue **MEDICAL CAUTION FORM REVIEWED:** Yes

DISEASES: March 1995 - Dilantin toxicity (117 mol/L)

MEDICATION: See Current Medication Profile

DIAGNOSES:
Developmental encephalopathy.
Epilepsy - generalized tonic clonic seizures (infrequent)
History of fractured left hip 1978.
Behaviour problem - aggressivity.
Heptavax.

REMARKS: Nozinan reduction in the past led to severe behaviour problems (last time in 1992).

[redacted]
M.D.
Primary Physician.

/lf

cc: Physician/Primary Nurse

MEDICAL ASSESSMENT - HRC ORILLIA

NAME: [redacted] **CB#:** [redacted] **LOCATION:** C10 **DATE:** 1997 April 23

DATE OF ADMISSION: 1973 December 03 **BIRTHDATE:** 1961 [redacted] **SEX:** Male

HEIGHT: 170.5 cm. **WEIGHT:** 70.6 kg. **DATE OF LAST ASSESSMENT:** 1995 September 25

HEAD & NECK: Average.

EYES: P.E.R.L.A. Fundi grossly normal.

EARS & NOSE:
Clean. Tympanic membranes pink. Light reflex adequate.
Nose: no discharge.

TEETH, THROAT & PALATE: Teeth attended. Throat not inflamed.

THYROID: Not enlarged. No lymphadenopathy.

HEART/B.P.: **B.P.:** 90/70 **PULSE:** 88 regular
S1, S2 normal. No heart murmur heard. Peripheral pulses felt.
Peripheral circulation adequate.

BREASTS: N/A

LUNGS: Clear to percussion and auscultation.

ABDOMEN/HERNIA/RECTAL/ETC.:
Soft. No organomegaly and/or tenderness. Rectal examination average.

G.U. SYSTEM: Not circumcised. Testicles descended.

MENSTRUAL HISTORY: N/A

SKIN: Incisional scar left hip.

SKELETON: Average development.

NERVOUS SYSTEM:
Cranial nerves intact. Deep tendon reflexes symmetrical.
Babinski downgoing.

TBC TESTS: (1st) 1996 October 8 - negative
(2nd) 1996 October 21 - negative

INCOMPETENCY STATUS: To continue **MEDICAL CAUTION FORM REVIEWED:** Yes

DISEASES: 1996: May - fracture nasal bones
Oct. - sprain right ankle

PRESENT MEDICATION: Cogentin, Multivitamins, Nozinan, Phenobarb, Dilantin

DIAGNOSES:
Developmental encephalopathy.
Epilepsy - generalized tonic clonic seizures (infrequent)
History of fractured left hip 1978.
Behaviour problem - aggressivity.
Heptavax.

REMARKS: He is quite drowsy. Morning Nozinan dose of 30 mg. will be discontinued despite the history of increased undesirable behaviour in the past. At present, the behaviour is acceptable.

/lf

[redacted] M.D.,
Primary Physician.

cc: Primary Nurse/Physician
Nurse III

MEDICAL ASSESSMENT - HRC ORILLIA

NAME: [redacted] **CB#:** [redacted] **LOCATION:** C10 **DATE:** 1997 August 27

DATE OF ADMISSION: 1973 December 03 **BIRTHDATE:** 1961 [redacted] **SEX:** Male

HEIGHT: 170.5 cm. **WEIGHT:** 66 kg. **DATE OF LAST ASSESSMENT:** 1997 April 23

HEAD & NECK: Average.

EYES: P.E.R.L.A.

EARS & NOSE: No discharge. Tympanic membranes clear.

TEETH, THROAT & PALATE: Poor oral hygiene, gingivitis (Dilantin related).

THYROID: Not enlarged.

HEART/B.P.: **B.P.:** 140/78 **PULSE:** 88 regular. No heart murmurs.

BREASTS: N/A

LUNGS: Clear to percussion and auscultation.

ABDOMEN/HERNIA/RECTAL/ETC.: Soft, no organomegaly.

G.U. SYSTEM: **Not** circumcised, testicles descended.

MENSTRUAL HISTORY: N/A

SKIN: No rash.

SKELETON: No deformities.

NERVOUS SYSTEM: Deep tendon reflexes symmetrical. Babinski downgoing.

TBC TESTS: (1st) 1996 October 8 - negative
(2nd) 1996 October 21 - negative

INCOMPETENCY STATUS: To continue **MEDICAL CAUTION FORM REVIEWED:** Yes

DISEASES: 1997: May - Dilantin toxicity.

PRESENT MEDICATION: Cogentin, Multivitamins, Nozinan, Phenobarb, Dilantin

DIAGNOSES:
Developmental encephalopathy.
Epilepsy - generalized tonic clonic seizures (infrequent)
History of fractured left hip 1978.
Behaviour problem - aggressivity.
Heptavax.

REMARKS: **DISCHARGE PHYSICAL**
The gingivitis is most probably Dilantin related and perhaps Dilantin should be replaced with Epival and Phenobarb discontinued. No behaviour problem reported.

/lf

[redacted]
M.D.,
Primary Physician.