Traverse Independence
1-1382 Weber Street East – Kitchener, ON N2A 1C2
Phone 519-741-5845 – Fax 519-741-8731

MEDICAL REPORT

Traverse Independence is a personal health information custodian under the Ontario Personal Health Information Protection Act, 2004. We are committed to protecting the privacy, confidentiality and security of all personal information entrusted to us.

All our intake forms are available on our website www.traverseindependence.ca.

Note to Applicant: This form must be completed and signed by your physician.

Name of Applicant

Address

City/Province Postal Code

Phone Number Cell Number

Name of Physician

Address

City/Province Postal Code

Phone Number Fax Number

Diagnosis of Applicant's Disability

Primary Diagnosis

Secondary Diagnosis

a)

b)

c)

Infections/Diseases

☐ TB ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ MRSA ☐ HIV

☐ Other

Does the individual have any of these conditions? If yes, please specify.

Condition	Yes	No	Not Known	Specify
Acquired Brain Injury	☐ Yes	☐ No	☐ Not Known	
Cardiac or Respiratory Problems	☐ Yes	☐ No	☐ Not Known	
Urinary or Gastro-Intestinal Tract Problems	☐ Yes	☐ No	☐ Not Known	
Sensory or Perceptual Deficits	☐ Yes	☐ No	☐ Not Known	
Cognitive Difficulties	☑ Yes	☐ No	☐ Not Known	
Problems Swallowing	☐ Yes	☐ No	☐ Not Known	
Seizures - Controlled or Uncontrolled?	☐ Yes	☐ No	☐ Not Known	
Emotional or Psychiatric Issues	☐ Yes	☐ No	☐ Not Known	
History of Drug or Alcohol Related Issues	☐ Yes	☐ No	☐ Not Known	
Special Dietary Needs	☐ Yes	☐ No	☐ Not Known	
Tobacco Addiction	☐ Yes	☐ No	☐ Not Known	
Mental Health Issues	☐ Yes	☐ No	☐ Not Known	

Are there any significant findings in physical examination that would be important to know in planning for your patient's care?

Current Therapies or Treatments

Current Medications – Please attach current medication list.

Drug Name		Dosage		Condition treated	
Drug Name		Dosage		Condition treated	
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Can your client take his/her medication independently?

☐ Yes ☐ No If no, describe what kind of help is needed.

Other information

Physician's signature Date