

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 <u>www.traverseindependence.ca</u>.

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

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Name of Applicant			
Address		-	
City/Province		Postal Code	
Phone Number		Cell Number	
Name of Physician			
Address		_	
City/Province		Postal Code	

City/Province	Postal Code	
Phone Number	Fax Number	

Diagnosis of Applicant's Disability

Primary Diagnosis	
Secondary Diagnosis	
a)	
b)	
c)	

Infections/Diseases

□ 'ТВ	Hepatitis A	Hepatitis B	Hepatitis C	MRSA	
Other					

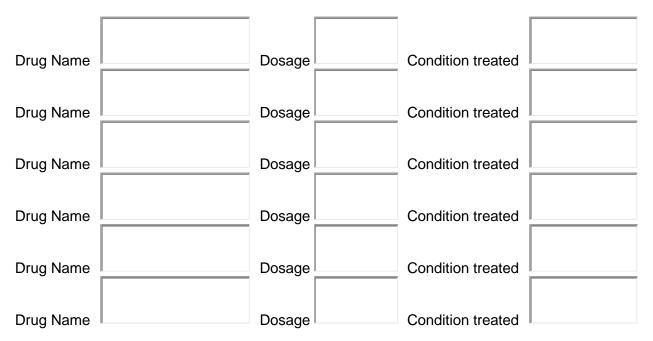
Does the individual have any of these conditions? If yes, please specify.

Acquired Brain Injury	Yes	No	□ Not Known	
Cardiac or Respiratory Problems	□ 'Yes	No	□ Not Known	
Urinary or Gastro- Intestinal Tract Problem		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.



Can your client take his/her medication independently?

	ļ	Yes	└ 'No	If no, describe what kind of help is needed
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Other information

Physician's signature

Date