**Last Updated: September 30, 2021**

Name

Pronouns | Phone | Email

**Medical History**

|  |  |  |
| --- | --- | --- |
| **Diagnosis/Health Condition/Surgery** | **When diagnosed/ procedure was completed (Year)** | **Notes:** |
|  |  |  |
|  |  |  |
|  |  |  |

**Known Allergies**

Allergy: *(e.g., pollen)*

 Severity & Symptoms: *(e.g., anaphylaxis)*

 Management: *(e.g., epi-pen)*

**Care Team**

|  |  |
| --- | --- |
| **Primary Care Provider (MD/NP):** Contact Information | Last visit: Next visit: Goals/Care Plan: |
| **Specialist:** Contact Information | Last visit: Next visit: Goals/Care Plan: |
| **Specialist:** Contact Information | Last visit: Next visit: Goals/Care Plan: |
| **Specialist:** Contact Information | Last visit: Next visit: Goals/Care Plan: |
| **Allied Health (OT/PT/SLP/RD):** Contact Information | Last visit: Next visit: Goals/Care Plan: |
| **Vision:** Contact Information | Last visit: Next visit: Goals/Care Plan: |
| **Dental:** Contact Information | Last visit: Next visit: Goals/Care Plan: |
| **Counselling (SW, RP, OT):** Contact Information | Last visit: Next visit: Goals/Care Plan: |
| **Traditional Healing:**Contact Information | Last visit:Next visit:Goals/Care Plan:  |

**Legend:**

*OT = Occupational Therapist*

*PT = Physiotherapist*

*SLP = Speech Language Pathologist*

*SW = Social Worker*

*RP = Registered Psychotherapist*

*NP = Nurse Practitioner*

*RD= Registered Dietitian*

**Medications**

Pharmacy:

Name of Medication

 Dosage

 Reason for taking it

 Date prescribed

OR

|  |  |
| --- | --- |
| **Name of Medication** |  |
| Dosage |  |
| Reason for taking it |  |
| Date prescribed |  |

OR

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Medication** | **Dosage** | **Time taken** | **Reason for taking it** | **Date prescribed** |
|  |  |  |  |  |
|  |  |  |  |  |

**Social History**

Occupation:

Living situation (i.e., alone, with spouse/child/parent, assisted living, group home, long-term care)

Primary support(s):

Power of Attorney:

Description of living environment (i.e., apartment, bungalow, townhouse, shelter)

 Stairs to entry:

 Stairs in home:

 Equipment in home (i.e., grab bars, stair lift, ramp, commode)

Source of income/ financial support (i.e., work, ODSP, OW, parents, children, spouse)

Access to health insurance? / Funding:

**Mobility devices used:**

(i.e., walker, cane, wheelchair)

Date received:

Vendor and Vendor Contact Information:

**Functional Status:**

(i.e., Independent, assistance, dependent, not applicable ; include needs description when applicable)

Meal preparation:

Grocery Shopping:

Money management:

Medication management:

Home management:

Communication:

Comprehension:

Memory:

Self-care:

 Bathing

Hygiene/grooming

 Dressing

 Toileting

 Eating

Transportation:

 Navigating community

 Driving

Leisure:

**Other:**

Nutrition/ dietary needs:

Sleep:

Checklist as something separate

Annual care for tests (e.g., echocardiogram, eye exam)

* On ILC/ EDS website