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Manitoba

Medical Assessment for Long Term Care

To be completed by Most Responsible Provider

MRN: Visit #:

Last Name, First Name:

Date of Birth (dd/mmm/yyyy)

Sex: ☐ Female ☐ Male

PHIN:

MB Reg #:

Date of Examination D D M M M Y Y Y Y **Location of Examination:**

Allergies & Intolerances (including reactions): ☐ No know allergies/intolerances

Medical and Surgical Diagnosis including Health History leading to long term care application

Infection Control Concerns:

Medications:

☐ Attach current medication list or Medication Administration Record (MAR)

☐ Antipsychotics/Hypnotics/Sedatives/Antidepressants/Anxiolytics & Indications *(include if medication was started in hospital or community)*:

____

____

____

Relevant Physical Exam:

Height: ____________ ☐ Feet and Inches ☐ cm **Weight:** ____________ ☐ lb ☐ kg

Is there active specialist involvement?

☐ No ☐ Yes (include name/specialty, indication for involvement and any planned follow-up):

____

____

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Last Name, First Name:

Date of Birth (dd/mmm/yyyy)

Sex: ☐ Female ☐ Male

PHIN:

MB Reg #:

Medical Assessment for Long Term Care

To be completed by most responsible provider

Substance Use History?

History of alcohol or other substance use disorder: ☐ No ☐ Yes: ______

Past Smoking: ☐ No ☐ Yes - If yes, indicate date of last use: ______

Current Smoking:

☐ No ☐ Yes- If yes, provide details of tobacco reduction plan: ______

______

Advance Care Plan (ACP) Status (attach copy)

☐ R - Resuscitation ☐ M - Medical ☐ C - Comfort

Is there a Health Care Directive? ☐ No ☐ Yes *(attach copy if available)*

Is a Health Care Proxy Identified? ☐ No ☐ Yes

Tuberculosis screening:

Chest X-ray is NOT mandatory. Chest X-ray is only required in the following situations:

☐ The client has active respiratory or systemic symptoms suggestive of TB*

Cognition:

Has cognition been assessed & documented?

☐ Not Required ☐ Yes *(attach report)*

If yes, indicate: Test: ______

Date: ______

Score: ______

Capacity:

Has capacity been assessed?

☐ No

☐ Yes - competent *(attach report)*

☐ Yes - incompetent *(attach report)*

Name of Primary Care Provider (PCP) *(if not PCP completing this form)*: ______

______

Completed by:

______ PRINTED NAME AND CLASSIFICATION

______ SIGNATURE

Date D D M M M Y Y Y Y

______ ADDRESS

Phone: ___ - ___ - ____

FORM COMPLETION GUIDELINE & LEGEND:

- **Most Responsible Provider** - A physician/ nurse practitioner/physician assistant with the overall responsibility for directing and coordinating the care of a client at the specific point in time.
- **Allergies and Intolerances** - identify all known allergies and intolerances and include reaction. Check box if no known allergies/intolerances. If additional space required, append supplemental document.
- **Location:** identify where assessment has been completed ie- Primary Care Clinic, acute care, client's home.
- **Medical and Surgical Diagnosis:** There should be a current diagnosis for each medication. A single-word diagnosis should be supplemented with qualifiers and dates if relevant (e.g. 'stable angina' or 'Myocardial Infarction 2003' rather than 'IHD').
- **Health history leading to long term care application:** Provide details of current health history and care needs indicating need for long term care.
- **Infection Control Concerns:** Identify any known Antibiotic Resistant Organisms and/or isolation requirements.
- **Relevant Physical Exam:** Examples can include heart murmurs, tremors, artificial limbs/eyes, any neurological deficits (ie. old dilated pupil, facial droop or persistent weakness in one arm/leg, long-standing skin lesions, etc.) Include client's last recorded height and weight.
- **Medication: Antipsychotics/Hypnotics/Sedatives/Antidepressants/Anxiolytics & Indications:** Provide prescribing indication for all Antipsychotics / Hypnotics / Sedatives / Antidepressants / Anxiolytics. For individuals in hospital, identify if medication was initiated in hospital or community.
- **Is there active specialist involvement:** Identify specialists that are currently involved in care, any known planned follow-up. (e.g. Dr. Heart, Cardiologist. Send EKG every 6 months, next due July 2025)
- **History of alcohol or substance use disorder:** Check appropriate boxes. Identify any known history and if at risk of withdrawal and management plan. Include known information regarding tobacco, vaping, and cannabis use, specifying the types of products used, frequency of use, and any relevant history. Provide details of any reduction plan that may be in effect.
- **Cognition:** Check appropriate box. Cognition documented using objective tests if applicable (e.g. Mini-Mental Status Examination [MMSE], Montreal Cognitive Assessment [MoCA], or another type of test). If "yes" is checked, provide the most recent score with date and append copy of the assessment(s).
- **Capacity:** Check appropriate box. Append all supportive documentation.
- **Name of Primary Care Provider:** If this form is not completed by the client's Primary Care Provider, provide name of PCP should follow-up be required.
- **Avoid** abbreviations as much as possible.
- Append documents as indicated plus any relevant consults and diagnostic imaging

* For more information regarding TB: Think TB: For Healthcare Providers (https://healthproviders.sharedhealthmb.ca/files/think-tb-hcp.pdf)