TODAY'S VISIT

Main Reason for Today's Visit to the Physician or Nurse
(To be filled out by the Patient with DD and Caregiver)

- Please bring an updated form for each visit to the physician/nurse.
- Bring an updated medication list, or all medications being taken.
- Bring any monitoring forms being used (i.e., sleep or behaviour charts).
- Keep a copy of this completed form for the patient's home medical files.

Up-to-date Medication List attached? ☐

Name: _____ Gender: _____
(last, first)

Address: _____

Tel. No: _____

DOB (dd/mm/yyyy): _____

Health Card Number: _____

Date of Visit: _____

Patient / Caregiver (see back of page)

What is the main health problem the patient with DD or caregivers are concerned about?

When did it start? List any new symptoms. List possible contributing factors.

Circle or list other needs – e.g., prescription renewals, test results, forms to be filled out, appointment for annual exam

Any Recent Changes or Stressors? ☐ **No** ☐ **Yes:** _____
(e.g., staff changes, family illness or stress, changes in living or social environment)

Any recent visit to the dentist or other doctor? ☐ **No** ☐ **Yes:** _____

Any recent medication changes or additions? ☐ **No** ☐ **Yes:** _____
(include antibiotics, creams or herbal medicines)

Caregiver Needs – Write down or tell doctor or nurse whether there are issues regarding caregiver fatigue or burnout

Name/Position:	**Contact #:**	**Signature:**

PHYSICIAN / NURSE TO COMPLETE, KEEP COPY FOR CHART, AND GIVE COPY TO THE PATIENT / CAREGIVER

Physician / Nurses

Assessment:	
Treatment Plan including Medication Changes:	
Advice to Patient and Caregivers:	

Next Planned Visit / Follow-Up: _____ **MD / RN Signature:** _____

Recent Changes? If yes, check and briefly describe. Complete appropriate sections of monitoring chart below

- ☐ **Activity level**
- ☐ **Mobility**
- ☐ **Sleeping habits**
- ☐ **Pain or distress**
- ☐ **Eating patterns/Weight change**
- ☐ **Swallowing**
- ☐ **Bowel routine**
- ☐ **Mood or behaviour**
- ☐ **Other:** _____

MONITORING OF DAILY FUNCTIONS DURING THE PAST WEEK

	MON.	TUES.	WED.	THURS.	FRI.	SAT.	SUN.
ACTIVITY LEVEL (N, ↓ or ↓)							
SLEEP Pattern and Hours required (daytime and night)							
EATING/ WEIGHT (N, ↓ or ↓) Include total # of meals and # completed/day							
BOWEL ROUTINE (N, ↓, ↓, C)							
MOOD/ BEHAVIOUR (N, ↓ or ↓) Describe if changed (e.g., agitated, withdrawn)							

Fill in chart using: **N = Normal** or usual for that person; ↓ **= Decrease** in amount, level or function; ↓ **= Increase** in amount, level or function
C = Constipation – a stool is passed less often than every two days or stools are hard and/or difficult or painful to pass, even if the person has stools many times per week.