ROCK CREEK
OF OTTAWA

PHYSICIAN COMMUNICATION OF CHANGE IN RESIDENT FUNCTION

Patient Name: _____ DOB: _____

Physician Name: _____ Patient Phone Number: _____

Eating/Self Feeding
_____Food falls out of mouth
_____Cannot or will not chew
_____Unable to cut food
_____Cannot lift utensils
_____Poor lip closure/drooling
_____Heartburn
_____Difficulty feeding self
_____Food coming out of nose
_____Unable to open containers
_____Vomiting at or after meals
_____Pockets of food in cheeks
_____Coughing at/after meals
_____Difficulty swallowing medication

Transfers
_____Difficulty transferring
_____Loss of balance
_____Unable to move self in bed
_____Unable to get in/out of bed
_____Unable to get on/off toilet

Ambulation
_____Increased assistance with walking
_____Balance loss when walking
_____Shuffled gait
_____Difficulty propelling wheelchair

Cognitive
_____Difficulty following cues
_____Poor problem-solving skills
_____Difficulty remembering
_____Difficulty sequencing tasks
_____Unable to communicate needs

Grooming / Hygiene
_____Difficulty bathing self
_____Unable to clean self after toileting
_____Difficulty dressing
_____Difficulty combing hair or brushing teeth
_____Difficulty in washing face

Posture
_____Poor neck trunk control
_____Unable to sit upright in wheelchair
_____Difficulty looking to side
_____Bends over while walking

Safety
_____Frequent falls
_____Balance loss sitting/standing
_____Decreased vision
_____Poor safety awareness
_____Poor technique with walker, cane, or wheelchair

Physical Function
_____Decreased coordination
_____Decreased functional activity tolerance
_____Decreased leg ROM
_____Decreased leg strength
_____Decreased arm ROM
_____Decreased arm strength
_____Significant weight loss
_____Lower body contractures
_____Hand/arm contractures
_____Shakes or tremors

Physiological Changes
_____Swelling in _____
_____Pain in _____
_____Skin breakdown in _____
_____

Other Observations
_____
_____
_____
_____
_____
_____
_____

Nurse's Signature: _____ Date: _____

COMMUNICATION TO PHYSICIAN

We have assessed this resident to have experience a change in the above-listed functional areas. To prevent further decline, may we please have orders for out-patient therapy to evaluate? _____Yes _____No

Physician Signature: _____ Date: _____

SPECIAL INSTRUCTIONS

_____

_____

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