Ontario

Ministry of Long-Term Care

Health Assessment - Ontario Health atHome

Fixing Long-Term Care Act, 2021

Fee Code
K038

This form is to be used for completion of the health assessment required under the *Fixing Long-Term Care Act, 2021* when a person applies for a determination of eligibility for long-term care home admission. This assessment must be made by a physician or registered nurse in the general class or a registered nurse in the extended class. Please see the last page of this form for additional information.

PLEASE REVIEW FIRST - Status of Assessment

☑ **Initial Assessment**

If this is the first health assessment form being completed by this practitioner for this applicant, **please indicate the same by ticking the above box and complete all sections of this form**.

Note: For submissions through fax, please ensure to also fax any additional documents you wish to include with this assessment.

☐ **Reassessment**

If a health assessment form was previously completed by this practitioner for this applicant, **please indicate as a reassessment by ticking the above box and complete the below**:

If known, date of previous assessment submitted to Ontario Health atHome (yyyy/mm/dd):

Has there been a change in the applicant's health since that assessment?

☐ **Yes** (please complete **Applicant Information and Practitioner Information sections and only applicable sections** that reflect the change in the applicant's health since the previous assessment).

☐ **No** (please complete **Applicant Information, Practitioner Information sections** and sign the last page of the form).

Once completed, please submit this form and any additional documentation to Ontario Health atHome.

Ontario Health atHome Information (This section to be completed by the designated placement co-ordinator)

For questions about the completion of this form, please contact:

Ontario Health atHome contact

Last Name	First Name	Telephone Number ext.

Return completed form to:

Local Ontario Health atHome Office	Fax Number

Applicant's Information

Last Name	First Name	Middle Initial
Vance	Eleanor	J

Date of Birth (yyyy/mm/dd)	Health Card Number	Version Code	Expiry Date (yyyy/mm/dd)
05/21/1946	1234-567-890	YV	

Gender

☐ Male ☐ Female ☐ Other ▶ please specify _____ ☑ Unknown ☐ Undisclosed

Applicant's Mailing Address

Unit Number	Street Number	Street Name	PO Box
	456	Maple Avenue	

Lot Number	Concession	Rural Route

City/Town	Province	Postal Code
Toronto	ON	M4B 1B4

Applicant's Last Name	Applicant's First Name	Health Card Number
Vance	Eleanor	1234-567-890

Medical Diagnoses

Please note: This section is intended to capture current health conditions to inform the individual's care needs in long-term care. **Where available, practitioners are strongly encouraged to include the cumulative patient profile.**

Additional Documentation

You are also encouraged to attach additional documentation relevant to the applicant's current health conditions where available. Examples of relevant documents include geriatric and/or psychogeriatric assessments; specialist consult notes; medical tests; hospital discharge reports/summaries; occupational therapy/physiotherapy assessments/notes; speech pathologist reports (e.g., swallowing assessment); social worker assessments/notes; GAIN assessment; goals of care.

Please note: It will be assumed that the practitioner has obtained the applicant's consent, where required, to share any additional attachments (e.g., psychiatric assessments).

☐ **Cumulative patient profile is attached**

If cumulative patient profile is **not attached**, please list the applicant's active and relevant historical medical diagnoses below:
Osteoarthritis, Hypertension, Type 2 Diabetes

Advance Care Planning **(☐ Information is attached)**

Please share any information about advanced care planning and/or end of life care planning or requirements, where known:
Goal of Care: To remain living safely and independently in own home with support.

Practitioner has discussed advanced care planning and/or end of life care with (select all that apply):

☐ Applicant ☐ Applicant's Family ☐ Substitute Decision Maker ☑ Not known

☐ Other: _____

Additional Comments
Goal of Care: To remain living safely and independently in own home with support.

Applicant's Last Name	Applicant's First Name	Health Card Number
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Current Medications (☐ Information is included in the cumulative patient profile attached)

Please provide a comprehensive list of the applicant's current medications. It is very important for long-term care homes to have knowledge of the following priority medications for continuity of care where they have been prescribed: **Benzodiazepines, Antipsychotics, Other Psychotropic Drugs, Opioids, Diuretics/Antiglycemics.**

Where any priority medications have been prescribed, please provide the name and purpose of the medication being prescribed and additional information where known.

☐ **List of applicant's current medications is attached to this form.**

If list is not attached, please provide the applicant's current medications.
Note: Include prescription, non-prescription, supplements (where known), as applicable.

Oxygen	If "Yes", please specify:	If known, please specify:
☐ Yes ☑ No	☐ Tank ☐ Concentrator ☐ Unknown	☐ Continuous: _____ Rate: _____ (L/min) ☐ With Exertion / As Required Rate: _____ (L/min)

If any specific drug has been discontinued in the past 3 months, please specify:

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Allergies (☐ Information is included in the cumulative patient profile attached)

Does the applicant have any known severe allergies? (e.g., drugs, food, latex, stinging insects/Hymenoptera)

☐ Yes ☐ No ☑ Not known

If "Yes," please specify and provide additional information as applicable (e.g., severity, type of reaction, if EpiPen/auto-injector is required, treatment)

Vaccinations (Where Known) (☐ Information is included in the cumulative patient profile attached)

Date of last Tetanus-Diphtheria (Td) (yyyy/mm/dd) _____

Date of last Tetanus-Diphtheria, acellular pertussis (Tdap) vaccine (yyyy/mm/dd) _____

Date of pneumococcal vaccine (yyyy/mm/dd) _____

Date of last COVID-19 vaccine (yyyy/mm/dd) _____

Date of last flu shot (yyyy/mm/dd) _____

Date of last respiratory syncytial virus (RSV) vaccine (yyyy/mm/dd) _____

Substance Use Disorder(s) or Dependence

Note: This section is intended to capture alcohol, nicotine, and/or other substance use disorders or substance dependence.

Does the individual have a substance use disorder, or substance dependence?

☐ Yes/Suspected ☑ No

If "Yes/Suspected," please specify:

☐ Nicotine Dependence (☐ Smoking ☐ Other (e.g., chewing, gum, patch): _____)

☐ Alcohol

☐ Cannabis (☐ Smoking ☐ Other (e.g., vaping, eating, drinking): _____)

☐ Opioids

☐ Benzodiazepines

☐ Other: _____

Is applicant on methadone maintenance treatment or receiving other treatment for Opioid Use Disorder?

☐ Yes ☑ No

If "Yes", please provide name and contact information of prescribing physician, where known:

Last Name	First Name	Telephone Number

If known, provide the address and contact information of the associated pharmacy:

Name of Pharmacy	Telephone Number

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Additional comments (e.g., history of substance use):

Applicant's Last Name	Applicant's First Name	Health Card Number
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Responsive Behaviours

Where known, indicate and describe any current behaviour(s) or behaviour(s) in the last 12 months:

☐ Wandering ☐ Physical ☐ Verbal ☐ Sexual ☑ None ☐ Not Known

☐ Other (specify): _____

Additional details regarding above behaviours (frequency of exhibited behaviours, triggers, interventions, etc.)

Alert and oriented. No cognitive impairment noted.

Wounds (☐ Information is included in the cumulative patient profile attached)

Does the applicant have any wounds?

☐ Yes ☐ No ☑ Not known

If “Yes,” please specify the type of wound(s):

☐ Post-surgical ☐ Pressure Ulcer ☐ Diabetic Ulcer ☐ Other: _____

Does the applicant use a Vacuum Assisted Closure (VAC) for a wound?

☐ Yes ☐ No ☑ Not known

Does the applicant have a wound care specialist?

☐ Yes ☐ No ☑ Not known

If “Yes”, provide name and contact information, where known:

Last Name	First Name	Telephone Number

Additional Information (e.g., history of wounds, location of wound, stage of pressure injury/injuries, current wound care treatment, specialty supplies required):

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Tuberculosis (TB) Screening

Part 1: Symptom Screen

☐ Symptom Screen Completed

☐ Symptom Screen **Not** Completed

Note: The Ministry of Long-Term Care has removed the requirement for a TB chest x-ray for all applicants to long-term care, and requires it only for symptomatic individuals

Symptoms include new or worsening cough (lasting three or more weeks); hemoptysis (coughing up blood); non-resolving pneumonia; fever; unexplained weight loss; night sweats; loss of appetite (anorexia); extreme fatigue; lymphadenopathy; chest pain (unexplained); dyspnea (unexplained).

Has the applicant developed new or worsening symptoms?

☐ Yes – Chest x-ray required. Please attach results and include any additional action taken, as applicable:

☑ No – Please proceed to Risk Factor Screen.

If symptoms were present but testing was negative, please proceed to the Risk Factor Screen.

Part 2: Risk Factor Screen

☐ Risk Factors Screen Completed

☑ Risk Factors Unknown / Screen **Not** Completed

Where possible, asymptomatic individuals should be screened for risk factors. This information is useful for long-term care patient management.

Risk Factors for TB infection include being born in or recently travelled to a TB endemic region (3+ months to a high TB incidence area or cumulative in one's lifetime); has lived, worked, or spent time in regions or settings in Canada where TB exposure is known to be high; previously stayed in a correctional facility or shelter; has experienced homelessness or being underhoused; persons who inject drugs and/or with a substance use disorder.

Are you aware of any risk factors for TB in the applicant?

☐ Yes ☑ No

If "Yes", please specify:

Please note: Once indicated whether any risk factor(s) apply, no further action is required.

Antibiotic Resistant Organism (ARO) Screening

Where known, has an ARO screening been completed for the applicant within the past 6 months?

☐ Yes ☐ No ☑ Not known **If "Yes", please attach results and provide action taken.**

Action taken and/or additional comments:

Medical Devices and Assistive/Adaptive Devices

Does the applicant use any medical and/or assistive/adaptive device(s)?

☑ Yes ☐ No ☐ Not known

Where known, please select the type below:

☐ Bi-level positive airway pressure system (BiPAP)

☐ Continuous positive airway pressure system (CPAP)

☐ Power wheelchair

☐ Bariatric wheelchair

☐ Continuous glucose monitors and supplies

☐ Insulin pump and supplies

☐ Peritoneal dialysis equipment or supplies

☑ Other: Walker

Additional comments/specifications

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Practitioner Information

Is the practitioner that is completing the health assessment the applicant's primary care provider?

☐ Yes ☐ No ☐ No primary care provider

If "No", please specify name of primary care provider, if known:

Last Name	First Name

Is the primary care provider willing to continue to provide care after applicant's admission into a long-term care home?

☐ Yes ☐ No ☑ Not known

Name and designation of practitioner completing the health assessment:

☐ Physician ☑ Registered Nurse ☐ Registered Nurse (Extended Class)

Last Name	First Name	Telephone Number
Chen	Sarah	

Mailing Address

Unit Number	Street Number	Street Name	PO Box
	456	Maple Avenue	

Lot Number	Concession	Rural Route

City/Town	Province	Postal Code
Toronto	ON	M4B 1B4

Signature of Practitioner	Date (yyyy/mm/dd)
	02/10/2026

Legislative Requirement

This form is to be used for completion of the assessment required under the *Fixing Long-Term Care Act, 2021* when a person applies for a determination of eligibility for long-term care home admission. The required assessment is of the applicant's physical and mental health, and the applicant's requirements for medical treatment and health care. This assessment must be made by a physician or registered nurse.

Determination of Eligibility and Long-Term Care Admission Process

This assessment, and other information about the applicant, will be used by the designated placement coordinator, Ontario Health atHome (OHaH), to determine whether the applicant is eligible for admission into a long-term care home. If the applicant is determined eligible, this assessment will be provided to the long-term care home(s) selected by the applicant so that the home(s) may decide whether or not to approve the person's admission. The home(s) will review this assessment to determine whether it lacks the physical facilities or nursing expertise necessary to meet the applicant's care requirements. It is essential that comprehensive, complete, and accurate information about the person applying for admission be provided. It is also essential that this information be provided in a timely way to prevent delays in the admission process.

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