



Oasis Medical Group

Cayman Ltd.

Geriatric Consult Form

Initial History

Patient Name: _____ Date of Birth _____

Address: _____ Town: _____ State _____ Zip _____

Phone: () _____

Residence: _____ Live alone

_____ Live with others

Relative/ Friend Contact: _____ Relationship: _____

Address: _____ Town: _____ State: _____ Zip: _____

Phone: () _____

Pharmacy: _____ Town: _____ Phone: () _____

Current and Past Medical History

What are your current medical concerns? _____

How is this problem affecting your daily life? _____

Do you presently have any other medical problems? _____

List any Surgical Procedures you have had

Procedure

Date

a) _____

b) _____

c) _____

d) _____

List all the medications you are presently taking; both those you take daily and those you just take once in a while. Please include Vitamins, mineral supplements, laxatives, stool softeners, and prescription skin preparations. If you cannot remember the names write a '?' and bring the medicines with you to your next visit.

Medicine Name

Strength

How Often

Reason



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List any allergies you have, including drug allergies: _____

How do you rate your health?

_____ excellent _____ good _____ fair _____ poor _____ bad

Falls

Have you fallen in the past year? _____ Yes _____ No

Have you cut down your activities because of a fall? _____ Yes _____ No

If "yes" what are they: _____

Alcohol

Have you ever felt you should cut down on your drinking? _____ Yes _____ No

Have people annoyed you by criticizing your drinking? _____ Yes _____ No

Have you ever felt bad or guilty about your drinking? _____ Yes _____ No

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? _____ Yes _____ No

Smoking

Current smoker _____ Former smoker _____

stopped in year of _____ Never smoked _____

Are you on a special diet? _____ Yes _____ No

If "yes" please describe: _____

A Little About You

Do you have any hobbies? List two things that you particularly enjoy.

1)

2)

Please list three interesting things about yourself. For example, "Is a life long Boston Red Sox Fan" or "Was a teacher."

1)

2)

3)



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PHYSICAL SELF MAINTENANCE SCALE (PSMS)

Circle the number to the right of the statement that best describes you in regards to the following activities.

1. Do you eat
 - a. without any help, 3
 - b. with some help (cutting food, identifying for blind, etc.), or 2
 - c. does someone feed you? 1

2. Do you dress and undress yourself
 - a. without any help (pick out clothes, dress and undress yourself), 3
 - b. with some help (dressing or undressing), or 2
 - c. does someone dress and undress you? 1

3. Do you take care of your own appearance, things like combing your hair, shaving (for men)
 - a. without help, 3
 - b. with some help, or 2
 - c. does someone do these things for you 1

4. Do you get around your house/apartment/room
 - a. without help of any kind (except for cane), 3
 - b. with some help (from a person, walker, crutches, chair), or 2
 - c. don't get around your home at all unless someone moves you 1

5. Do you get in and out of bed
 - a. without help 3
 - b. only with some help from a person or device, or 2
 - c. don't get in and out of bed unless someone lifts you 1

6. Do you bathe- that is, take a bath, shower, or sponge bath
 - a. without any help, 3
 - b. with some help from a person or device, or 2
 - c. Only when someone bathes you (lifts you in and out, or bathes) 1

7. Do you have trouble getting to the bathroom on time?
 - a. yes 1
 - b. no 2

8. About how often do you wet/soil yourself during the day or night
 - a. Never 4
 - b. Less than once a week 3
 - c. Once or twice a week 2
 - d. Three times or more a week 1



INSTRUMENTAL ACITIVITIES OF DAILY LIVING SCALE (IADL)

Circle the number to the right of the statement that best describes your/subject's ability with the following tasks.

A. Ability to use telephone

- | | |
|--|---|
| 1. Operate telephone on own initiative; Looks up and dials numbers | 1 |
| 2. Dials a few well-known numbers | 1 |
| 3. Answers telephone but does not dial | 0 |
| 4. Does not use the telephone at all | |

B. Shopping

- | | |
|---|---|
| 1. Takes care of all shopping needs independently | 1 |
| 2. Shops independently for small purchases | 0 |
| 3. Needs to be accompanied on any shopping trip | 0 |
| 4. Completely unable to shop | 0 |

C. Food preparation

- | | |
|---|---|
| 1. Plans, prepares and serves adequate meals independently | 1 |
| 2. Prepares adequate meals if supplied with ingredients | 0 |
| 3. Heats, serves and prepares meals or prepares meals but does not maintain adequate diet | 0 |
| 4. Needs to have meals prepared and served | 0 |

D. Housekeeping

- | | |
|---|---|
| 1. Maintains house alone or with occasional assistance (i.e. heavy work) | 1 |
| 2. Performs light daily tasks such as dishwashing, bed making | 1 |
| 3. Performs light daily tasks but cannot maintain acceptable level of cleanliness | 1 |
| 4. Needs help with all home maintenance tasks | 1 |
| 5. Does not participate in any housekeeping tasks | 0 |

E. Laundry

- | | |
|--|---|
| 1. Does personal laundry completely | 1 |
| 2. Launders small items; i.e. rinses stockings | 1 |
| 3. All laundry must be done by others | 0 |

F. Mode of transportation

- | | |
|--|---|
| 1. Travels independently on public transport or drives own car | 1 |
| 2. Arranges own travel via taxi, but does not otherwise use public transport | 1 |
| 3. Travels on public transport when accompanied by another | 1 |
| 4. Travel limited to taxi or car with the assistance of another | 1 |
| 5. Does not travel at all | 0 |

G. Responsibility for own medications

- | | |
|---|---|
| 1. Is responsible for taking medication in correct dosages at correct time | 1 |
| 2. Takes responsibility if medication is prepared in advance in separate dosages. | 0 |
| 3. Is not capable of dispensing own medication | 0 |

H. Ability to handle finances

- | | |
|--|---|
| 1. Manages financial matter independently (budgets, writes checks, pays rent, bills go to bank, collects and keeps track of income). | 1 |
| 2. Manages day-to-day purchases, but needs help with banking or major purchases | 1 |
| 3. Incapable of handling money | 0 |



PATIENT REGISTRATION FORM-RESIDENT ONLY

101 Centennial Tower, 2454 West Bay Rd. Grand Cayman, P.O. Box 3178, KY1-1207 Cayman Islands
Email: omgcayman@gmail.com Tel: (345) 943-6066

Please complete this form as accurately as possible. If you require help to do this. We will be happy to assist you. All information is strictly confidential. Please return to reception upon completion.

Full Name _____

First name Middle name(s) last Name

Your date of birth ____ / ____ / ____ Mother Name _____
dd mm yyyy

Male Female Country of birth _____

Residency: Caymanian Status Holder Resident Nationality _____

Primary spoken language: English Spanish Others _____

P.O. Box _____ Postal Code: KY _____

Email Address: _____

Residential Address in Cayman _____

Telephone #: _____
Home Mobile Work

If under the age of 16, please give contact details of parent/guardian: _____

Your employer's address and name: _____

Your occupation _____ Husband or wife's workplace _____

Religion _____ Do you have any spiritual/cultural beliefs that may impact upon the treatment which you will receive at OMG? Yes No

If yes, please describe: _____

Next of kin: _____ Relationship _____
Fist Name & Last Name Telephone# DOB: dd / mm / yyyy

Emergency contact, if different from next of kin: _____
Name: Telephone#:

Insurance details: Not Insure Insured

| | | |
|-----------------------|-------------------------------|---------------|
| Insurance Company | Type of Plan | Insurance # |
| Name of policy Holder | Relationship to Policy Holder | Policy group# |

I confirm that the information I have provided on this form. To the of my knowledge is true and correct

Signature:

Date:



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IDENTIFICATION

CHART NUMBER: _____

NAME: _____

Sex: M F Date of Birth _____

Patients Past Medical History

| | | | | | | |
|-----------------------------|-----|----|--|-----------------------|-----|----|
| Chest Pain | Yes | No | | Stroke | Yes | No |
| Bleeding Problem | Yes | No | | Cancer | Yes | No |
| Diabetes | Yes | No | | Seizure/ Fainting | Yes | No |
| High Blood Pressure | Yes | No | | Heart Attack | Yes | No |
| Heart Problems | Yes | No | | HIV/AIDS | Yes | No |
| Lung Disease | Yes | No | | Psychiatric Problem | Yes | No |
| Liver Disease | Yes | No | | Arthritis | Yes | No |
| Stomach Problems | Yes | No | | Thyroid Disorder | Yes | No |
| Gynecology Problems | Yes | No | | Kidney Problems | Yes | No |
| Migraines | Yes | No | | Gall Bladder Problems | Yes | No |
| Sexual Transmitted Diseases | Yes | No | | Asthma | Yes | No |
| Any other medical condition | Yes | No | | SMOKER | Yes | No |

Have you ever had surgery? Yes No (If yes. Please give details):

Allergy history:

Medication that allergic to:

Family Medical History: (Blood relatives only)

| | | | | | | |
|------------------|-----|----|--|---------------------|-----|----|
| Diabetes | Yes | No | | Strokes | Yes | No |
| Seizures | Yes | No | | Heart Attack | Yes | No |
| Chest Pain | Yes | No | | Cancer | Yes | No |
| Bleeding Problem | Yes | No | | High Blood Pressure | Yes | No |

Other:

Date completed this form: _____



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General Consent Treatment

I consent to attending the Oasis Medical Group. I further consent to, and authorize my attending physician, his/her assistants and OMG staff to perform such examinations, diagnostic investigations, and treatment as deemed necessary. I understand that I may, at any time, refuse to undergo any particular procedure or accept any recommendations for treatment.

Consent to Release of Information

I agree that a copy of my medical record may be provided to my physician and or designate referral upon request. I hereby authorize OMG to release my information requested by my insurance company with respect to any claim made pursuant to the authorization.

Financial Responsibility and Assignment of Benefit Declaration

I assume full responsibility for all health not covered by any other agency/payer and for any additional cost that are not entirely covered by my insurance plan. I hereby assign to Oasis Medical Group all benefits provided to my health insurance coverage plan or so much thereof to satisfy my indebtedness or that of my dependent. I authorize my insurance company to make payment for service directly to OMG without further signature.

My signature below verifies that I consent to the above conditions and that I have read the terms and conditions printed overleaf, understand the same, and agree to abide by them.

Name of Patient/Parent/Guardian

Signature of patient/parent/guardian

Relationship to patient

Witness

Date