(Date Received: _____)

CONFIDENTIAL MEDICAL REPORT

1. This Medical Report is required by Heartland Housing Foundation for each applicant seeking tenancy in seniors' apartments and lodges.
2. Failure to complete application in its entirety will result in a delay in processing.
3. Applicants may apply to **either** lodge facilities or apartment facilities.
4. Complete Medical Report and return to **the location being applied for**.

___ *Silver Birch Lodge* (780) 467-7018
___ *Silver Birch Manor* (780) 467-7018

___ *Apple Blossom Manor* (780) 467-9805
___ *Clover Bar Lodge* (780) 467-9805
___ *Lakeside Legion Manor* (780) 467-9805

___ *Dr. Henry House* (780) 998-0352
___ *Dr. Turner Lodge* (780) 998-0352
___ *Homestead Place* (780) 998-0352
___ *Lions Haven* (780) 998-0352

Note to Examining Physician

Heartland Housing Foundation facilities are rented only to seniors who are capable of administering to their own personal needs. Our staff are NOT qualified or permitted to dispense medication or to provide physical assistance. Meals or housekeeping services are NOT provided in our apartments. Our lodges provide meals and housekeeping services. Nursing care or special diets are not available. (Any charge for completion of this form is the responsibility of the applicant.)

APPLICANT

☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms.

Name: _____ Phone #: _____
(Last) (First)

Address: _____
(Street/Box/Apartment) (Town/City) (Province) (Postal Code)

Birth Date: _____/_____/_____ Alberta Health Care #: _____
Day Month Year

PHYSICAL EXAMINATION

	GOOD	IMPAIRED	COMMENTS
Sight			☐ Wears glasses
Hearing			☐ Wears Hearing Aid
Mobility			☐ Cane ☐ Walker ☐ Wheelchair
Communication			If impaired, please provide details below:

MEDICAL DIAGNOSIS	PROGNOSIS	COMMENTS

CURRENT MEDICATION	DOSAGE	FREQUENCY
Oxygen: ☐ Yes ☐ No	If yes,	If yes,

Is the applicant independent in complying with their medication regime? :
☐ Yes ☐ No If no, please describe the assistance you would recommend:

_____

_____

_____

Drug Allergies: ☐ Yes ☐ No Other Allergies: ☐ Yes ☐ No
If yes, specify including drug intolerances: _____

_____

_____

_____

ACTIVITIES OF DAILY LIVING

ASSISTANCE	NONE NEEDED	SUPERVISION	PARTIAL	FULL
Washing				
Grooming/Shave				
Bathing				
Dressing				
Feeding				
Toileting				

INCONTINENCE

	NONE	PARTIAL	COMPLETE	INTERVENTION	MANAGES CARE
Bladder				☐ Catheter	☐ Yes ☐ No
Bowel				☐ Colostomy	☐ Yes ☐ No

MENTAL CONDITION

	NO	SOMETIMES	YES	COMMENTS
Co-operative				
Aggressive				
Wanderer				
Confused				
Destructive				
Unpleasant Habits				
Dementia				
Depression				

Do you consider this applicant to be mentally and physically suitable to enter the following: **Choose One**

Lodge: ☐ Yes ☐ No Please comment: _____

_____

_____

Apartment: ☐ Yes ☐ No Please comment: _____

_____

_____

Will you be the attending physician when the applicant moves into our facilities?

☐

Yes ☐ No How long has the applicant been your patient? _____

Previous physician, if less than 6 months: _____

EXAMINING PHYSICIAN

Physician's Name Printed: _____

Address: _____
(Street/Box #) (Town/City) (Province) (Postal Code)

Physician's Phone Number: _____ **Date of Examination:** ____/____/____
(Day/Month/Year)

Physician's Signature: _____

Authorization for Release of Information

I, _____ hereby authorize and instruct Doctor _____ to release to Heartland Housing Foundation the information requested, and I hereby waive any and all claims against the person or organization releasing the report, or any of its officers, servants, agents, staff members or employees for any purpose whatsoever in connection with the communication and disclosure of the said information.

I understand that this personal information is being collected in accordance with the Freedom of Information and Protection of Privacy Act (FOIP), and I consent to said collection. For questions about the collection and use of your personal information, contact the FOIP Coordinator at Heartland Housing Foundation at (780) 400-3500.

Applicant's Signature: _____ **Date:** _____

Witness' Signature: _____ **Date:** _____