Medical Report

AUTHORIZATION FOR RELEASE OF INFORMATION FROM THE MEDICAL REPORT

I, ____, hereby authorize and instruct ____ to

(Applicant) (Physician)

release the medical information requested by Green Acres Foundation, 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.

Date: ______________________________ **Applicant's Signature:** ____

Date: ______________________________ **Witness:** ____

Green Acres Foundation provides affordable Lodge accommodations to ambulatory seniors who have the mental and physical capabilities to perform daily living skills independently with controlled behavior and good judgment/decision making abilities. Applicants must have continence of bowels and bladder or have managed incontinence.

Last Name: ____________________________________ **First Name:** ____________________________________

Date of Birth: ____________________________________ **(mm/dd/yy)**

Date of Last Examination: ______________________________ **(mm/dd/yy)**

Personal Health Care No.: ______________________________ **How long has applicant been a patient of yours?** __________

Has the applicant had a serious illness or injury within the past year? □ Yes □ No

If "yes", please give particulars____

____

Does the Applicant use any of the following?	**Yes**	**No**		**Yes**	**No**
Hearing Aid			Incontinence Supplies		
Pacemaker			Colostomy		
Oxygen			Mobility Aid(s): ____________________		

Is the applicant currently receiving Homecare? □ Yes □ No

If yes, how many hours per week and for what types of service? ____

____

Name(s) of other support agencies involved? ____

Please return completed form to:
Green Acres Foundation * 122 – 5th Avenue South * Lethbridge, AB * T1J 0S9
Phone: (403) 328-1155 * Fax: (403) 328-6370

Physical Findings:

Is there past or present evidence of:	Yes	No	If YES, give particulars (Please attach additional information if required)
Heart Disease:	☐	☐	______________________
Arthritis:	☐	☐	______________________
Diabetes:	☐	☐	______________________
High Blood Pressure:	☐	☐	______________________
Stroke:	☐	☐	______________________
Incontinence (Bowels):	☐	☐	If Yes, ☐ Mild ☐ Moderate ☐ Severe
Incontinence (Bladder):	☐	☐	If Yes, ☐ Mild ☐ Moderate ☐ Severe
Renal Failure:	☐	☐	If Yes, ☐ Mild ☐ Moderate ☐ Severe
Respiratory Deficiencies:	☐	☐	______________________
Nutritional Deficiencies:	☐	☐	______________________
Depression:	☐	☐	______________________
Cognitive Impairment:	☐	☐	If Yes, ☐ Mild ☐ Moderate _____ MMSE
Alzheimer's Disease:	☐	☐	If Yes, ☐ Mild ☐ Moderate ☐ Severe
Wandering:	☐	☐	______________________
Mental Illness:	☐	☐	______________________
Uncontrolled, Aggressive or Violent Behavior:	☐	☐	______________________
Parkinson's Disease:	☐	☐	If Yes, ☐ Mild ☐ Moderate ☐ Severe
Drug Sensitivity or Allergies:	☐	☐	______________________
Infectious Diseases:	☐	☐	If Yes, Type: ______________________
Alcohol or Drug Abuse:	☐	☐	If Yes, ☐ Past ☐ Present Details: ______________

A lodge provides meals, housekeeping services and 24-hour non-medical supervision. Given this information, is your patient independent enough to:

1.	Physically manage personal care including dressing?	☐ Yes	☐ No	☐ Unknown
2.	Ambulate to and from a central, congregate dining room?	☐ Yes	☐ No	☐ Unknown
3.	Maintain an appropriate level of personal hygiene?	☐ Yes	☐ No	☐ Unknown
4.	Perform daily living skills, without cueing or reminders?	☐ Yes	☐ No	☐ Unknown
5.	Socially fit in with other seniors?	☐ Yes	☐ No	☐ Unknown
6.	Administer his/her own medications?	☐ Yes	☐ No	☐ Unknown

General Remarks and other pertinent medical information: ______________________________

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Name and address of Physician completing application:

THIS MEDICAL REPORT IS VALID FOR 3 MONTHS

Name: ______________________________

Clinic Phone No.: ______________________________ Clinic Address: ______________________

Clinic Fax No.: ______________________________ ______________________

Signature: ______________________________ ______________________

This confidential information is being collected in accordance with the Alberta Housing Act, in that it relates directly to and is necessary to determine eligibility of applicants for the Green Acres Foundation Lodge Program.
For questions regarding this information, please contact the Green Acres Foundation.