



Medical Assessment Report

Green Acres Foundation apartments and cottages are for independent senior citizens. The term independent means the tenant must have the ability to care for themselves (cooking, cleaning and personal hygiene); as well, the person must have the mental capabilities to live in a congregate living environment and have the necessary mobility to ambulate in case of an evacuation.

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize and instruct _____ to
(Tenant) (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: _____ Tenant's Signature: _____

Last Name: _____ First Name: _____

Date of Last Examination: _____ Alberta Health Care Number: _____

How long has this person been a patient of yours? _____

Has this person had a serious illness or injury within the past year? Yes No

If "yes", please give particulars _____

Is your patient 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? _____

Does your patient use a mobility aid? Yes No

If "yes", what type: Cane Walker Manual Wheelchair Motorized Wheelchair Scooter

Could this person evacuate from a multi-storey building independently in the event of an emergency? Yes No

An apartment is an independent living facility without supportive services. Given this information, is your patient independent enough to:

- | | | | |
|--|---------------------------|--------------------------|-------------------------------|
| 1. Physically manage personal care including dressing? | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| 2. Maintain an appropriate level of personal hygiene? | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| 3. Perform daily living skills, without cueing or reminders? | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| 4. Socially fit in with other seniors? | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| 5. Administer his/her own medications? | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| 6. Safely prepare meals using a stove and an oven? | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |
| 7. Maintain the cleanliness of their apartment? | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unknown |

Physical Findings:

Is there past or present evidence of:	Yes	No	If YES, give particulars (Please attach additional information if required)
Incontinence (Bowels):	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Incontinence (Bladder):	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Cognitive Impairment:	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, <input type="checkbox"/> Mild <input type="checkbox"/> Moderate _____ MMSE
Mental Illness:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Uncontrolled, Aggressive or Violent Behavior:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infectious Diseases:	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, Type: _____
Alcohol or Drug Abuse:	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, <input type="checkbox"/> Past <input type="checkbox"/> Present Details: _____

General Remarks and other pertinent medical information:

Name and address of Physician completing application:

THIS MEDICAL REPORT IS VALID FOR 6 MONTHS

Name: _____

Clinic Phone No.: _____ Clinic Address: _____

Clinic Fax No.: _____

Signature: _____

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

**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 questions regarding this information, please contact the Green Acres Foundation.**