Medical Report

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.

I, _____, hereby authorize and instruct Dr. _____ to 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 applicants 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: _____

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: _____
MRSA or other _____	☐	☐	_____

Supportive Living 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: _____

_____

Name and address of Physician completing application:

Name: _____

Clinic Phone No.: _____ Clinic Address: _____

Clinic Fax No.: _____ _____

Signature: _____ _____

THIS MEDICAL REPORT IS VALID FOR 3 MONTHS

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