



Medical Report

I, _____, hereby authorize and instruct Dr. _____ to
 (Applicant) (first name) (last name)
 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: _____

Green Acres Foundation provides affordable accommodations to ambulatory seniors who have the mental and physical capabilities to perform daily living skills independently with controlled behaviour and good judgment/decision making abilities. Applicants must have continence of bowels and bladder or have managed incontinence, as well as the necessary mobility to ambulate in case of an emergency.

Our apartments and cottages are for independent senior citizens. The term independent means the applicant 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.

Last Name: _____ First Name: _____
 Date of Birth: _____ (mm/dd/yy) Date of Last Examination: _____ (mm/dd/yy)
 Personal Health Care Number: _____ How long has applicant 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 Home Care? 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 (i.e. use stairs) a multi-storey building independently in the event of an emergency?

Yes No

Does the Applicant use any of the following?	Yes	No		Yes	No
Hearing Aid			Incontinence Supplies		
Pacemaker			Colostomy		
Oxygen					

Physical Findings:

Is there past or present evidence of:	Yes	No	If YES, give particulars (Please attach additional information if required)			
Heart Disease:	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Arthritis:	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>	_____			
High Blood Pressure:	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Stroke:	<input type="checkbox"/>	<input type="checkbox"/>	_____			
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
Renal Failure:	<input type="checkbox"/>	<input type="checkbox"/>	If Yes,	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Respiratory Deficiencies:	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Nutritional Deficiencies:	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Depression:	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Cognitive Impairment:	<input type="checkbox"/>	<input type="checkbox"/>	If Yes,	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	_____ MMSE
Alzheimer's Disease:	<input type="checkbox"/>	<input type="checkbox"/>	If Yes,	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Wandering:	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Mental Illness:	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Uncontrolled, Aggressive or Violent Behaviour:	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Parkinson's Disease:	<input type="checkbox"/>	<input type="checkbox"/>	If Yes,	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Drug Sensitivity or Allergies:	<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: _____			
MRSA or other:	<input type="checkbox"/>	<input type="checkbox"/>	_____			

Can your patient:			
1.	Physically manage personal care including dressing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
2.	Ambulate to and from a central, congregate common area?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
3.	Maintain an appropriate level of personal hygiene?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
4.	Perform daily living skills, without cueing or reminders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
5.	Socially fit in with other seniors?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
6.	Administer his/her own medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
7.	Safely prepare meals using a stove and an oven?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown
8.	Maintain the cleanliness of their suite/apartment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown

General Remarks and other pertinent medical information: _____

Physician Name: _____ Clinic 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

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 residency in a Green Acres Foundation facility. For questions regarding this information, please contact Green Acres Foundation