

|  |  |  |
| --- | --- | --- |
| Applicant: | Last Name: | Given Name: |
|  |  |
| Date of Birth: (MM/DD/YY) |  | Alberta Health Care Number: |  |
| Date of Last Examination: |  | Last Annual Physical: |  |
|  |
| Physicians Name:(printed) |  |
| Address: |  |  |
| Street/Box |  | Town/City |  | Postal Code |
| Office Phone: |  | Date of Examination: |  |
| Hospital Affiliation: |  | Physician’s Signature: |  |

**Application for Seniors Lodge - Medical Report**

**Please return completed form to:**

 **Peter Dawson Lodge, 614 1st street N, Vulcan, AB T0L 2B0**

**P: 403-485-2422 F: 403-485-2393 E: drc@marquisfoundation.ca**

|  |
| --- |
| **Authorization For Release Of Medical Information**I hereby authorize the release of all information requested by Marquis Foundation and waive any and all claims against the person or organization releasing the report, or any of its of 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 (FOIPP), and I consent to the said collection. For questions about the collection and use of your personal information, contact the Director of Resident Care at Marquis Foundation at 403-485-2422 |
| **Applicants Signature:** |  | **Date:** |  |
| **Witness:** |  | **Date:** |  |

|  |  |
| --- | --- |
| Is the Applicant’s current health stable? | * Yes Shape  Description automatically generated with medium confidence
 |
| Has the Applicant had serious medical issues within the past year? | * Yes Shape  Description automatically generated with medium confidence
 |
| If “yes” please provide details and current management: |
|  |
| Does the Applicant Have: | Yes | No | Applicant ability to manage without assistance: |
| Pacemaker |  |  |  |
| Colostomy Bag |  |  |  |
| Oxygen |  |  |  |
| Ileostomy Bag |  |  |  |
| Artificial Limb |  |  |  |
| Other Aids to Daily Living (specify) |  |  |  |

|  |  |
| --- | --- |
| Hearing | * Normal  Impaired  Absent  Hearing Aid
 |
| Visual | * Normal Impaired Absent  Good with Glasses
 |
| Mobility | * Excellent – no mobility aid  Good – minimal help with mobility aid
* Good – but dependent on mobility aid  Uses a wheelchair and can transfer in/out
* Confined to a wheelchair
 |
| Check any of the following mobility aids and frequency of use: |
| * Cane Regular Occasionally
 | * Walker Regular Occasionally
 |
| * Wheelchair  Electric or  Manual  Regular  Occasionally
 |
| * Scooter  Electric or  Manual  Regular  Occasionally
 |
| Special Diet | * Diabetic  Cut-up Food  Low Cholesterol  Gluten Free
 |
| * Low Fat  Minced Food  Pureed  Other:
 |
| Allergies | * Food  Medication  Environment Describe:
 |

# A picture containing plant  Description automatically generated

# Application for Seniors Lodge - Medical Report

 **Does the Applicant have any of the following disorders/conditions?**

|  |  |  |
| --- | --- | --- |
| Condition | Current | If “yes” please provide particulars (please attachaddition informal if required) |
| Yes | No |
| Heart Disease |  |  |  |
| High Blood Pressure |  |  |  |
| Stroke |  |  |  |
| Diabetes |  |  |  |
| Arthritis |  |  |  |
| Epilepsy |  |  | If yes, | * Mild
 | * Moderate
 | * Severe
 |
| Renal Failure |  |  | If yes, | * Mild
 | * Moderate
 | * Severe
 |
| Incontinence (bladder) |  |  | If yes, | * Mild
 | * Moderate
 | * Severe
 |
| Incontinence (bowel) |  |  | If yes, | * Mild
 | * Moderate
 | * Severe
 |
| Respiratory Deficiencies |  |  |  |
| Parkinson’s Disease |  |  | If yes, | * Mild
 | * Moderate
 | * Severe
 |
| Cognitive Impairment |  |  | If yes, | * Mild
 | * Moderate
 | * Severe
 |
| Alzheimer’s Disease |  |  | If yes, | * Mild
 | * Moderate
 | * Severe
 |
| Wandering |  |  |  |
| Mental Illness |  |  |  |
| Uncontrolled, Aggressive orViolent Behaviour |  |  |  |
| Socially inappropriate or Disruptive behaviour |  |  |  |
| Depression |  |  |  |
| Alcohol or Drug Abuse |  |  | If yes, | * Past
 | * Present
 | Details: |
| Infectious Diseases |  |  | If yes, | Type: |  |  |
| Smoking |  |  |  |
| Tuberculosis |  |  |  |
| Nutritional Deficiencies |  |  |  |
| Communication Difficulty? |  |  | Due to: Mental Causes Deafness* Speech Impediment Language Barrier

Details: |
| Marquis Foundation provides meals, Housekeeping Services and 24 Hour Non-Medical Supervision. Given this information is your patient, without assistance, able to: |
|  | **Yes** | **No** | **Comments** |
| Administer own medications |  |  |  |
| Physically manage care including dressing |  |  |  |
| Maintain appropriate level of personalhygiene |  |  |  |
| Is the Applicant able to independentlyambulate to and from the dining room in the lodge setting? |  |  |  |
| Live in a lodge setting without assistance such as reminders andprompting |  |  |  |
| Socially fit in and interact with other seniors |  |  |  |
| Does the Applicant require Home Care Services? |  |  |  |
| Is there any other support agencyinvolved? |  |  |  |

Any special concerns that have not been captured on the medical form, please attach explanation on a separate page.