



# MEDICAL REPORT

THIS MEDICAL REPORT IS VALID FOR 6 MONTHS

## AUTHORIZATION FOR RELEASE OF INFORMATION FROM THE MEDICAL REPORT

I, \_\_\_\_\_, hereby authorize and instruct \_\_\_\_\_ to release the medical information requested by Clover Living Limited Partnership, 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 said information.

**Date :** \_\_\_\_\_ **Applicant's signature** \_\_\_\_\_

**Date :** \_\_\_\_\_ **Witness :** \_\_\_\_\_

Clover Living provides affordable supportive accommodations to ambulatory seniors who have the mental and physical capabilities to perform daily living skills independently with controlled behaviour and good judgement/decision making abilities.

Applicants must have continence of bowels and bladder or have managed incontinence.

Last Name : \_\_\_\_\_ First Name : \_\_\_\_\_

Date of Birth : \_\_\_\_\_ Date of last examination : \_\_\_\_\_

Alberta Health Care Number: \_\_\_\_\_ 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 these past or present evidence of:	Yes	No	If YES, give particulars Please attach additional information if required
Heart Disease:	<input type="radio"/>	<input type="radio"/>	_____
Arthritis:	<input type="radio"/>	<input type="radio"/>	_____
Diabetes:	<input type="radio"/>	<input type="radio"/>	_____
High blood Pressure:	<input type="radio"/>	<input type="radio"/>	_____
Stroke:	<input type="radio"/>	<input type="radio"/>	_____
Incontinence (Bowels or Bladder):	<input type="radio"/>	<input type="radio"/>	If Yes, <input type="radio"/> Mid <input type="radio"/> Moderate <input type="radio"/> Severe
Respiratory Deficiencies:	<input type="radio"/>	<input type="radio"/>	_____
Nutritional Deficiencies:	<input type="radio"/>	<input type="radio"/>	_____
Depression:	<input type="radio"/>	<input type="radio"/>	_____
Cognitive Impairment:	<input type="radio"/>	<input type="radio"/>	If Yes, <input type="radio"/> Mid <input type="radio"/> Moderate <input type="radio"/> Severe
Alzheimer's Disease:	<input type="radio"/>	<input type="radio"/>	If Yes, <input type="radio"/> Mid <input type="radio"/> Moderate <input type="radio"/> Severe
Wandering:	<input type="radio"/>	<input type="radio"/>	_____
Mental Illness:	<input type="radio"/>	<input type="radio"/>	_____
Uncontrolled, Aggressive or Violent Behaviour:	<input type="radio"/>	<input type="radio"/>	_____
Parkinson's disease:	<input type="radio"/>	<input type="radio"/>	If Yes, <input type="radio"/> Mid <input type="radio"/> Moderate <input type="radio"/> Severe
Drug Sensitivity or Allergies:	<input type="radio"/>	<input type="radio"/>	_____
Infectious Diseases:	<input type="radio"/>	<input type="radio"/>	If Yes, Type : _____
Alcohol or Drug Abuse:	<input type="radio"/>	<input type="radio"/>	If Yes, <input type="radio"/> Past <input type="radio"/> Present Details: _____

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?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
2. Ambulate to and from a central, congregate dining room?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
3. Maintain an appropriate level of personal hygiene?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
4. Perform daily living skills, without cueing or reminders?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
5. Society fit in with other seniors?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
6. Administer his/her own medications?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown

Do you consider this applicant to be mentally & physically suitable to look after him/herself in a seniors lodge setting?

Yes     No

Name and address of Physician completing application:

Name : \_\_\_\_\_

Clinic Address: \_\_\_\_\_

Clinic Phone No: \_\_\_\_\_

Clinic Fax No: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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 Clover Living. For questions regarding this information, please contact the Clover Living,