Hythe and District Pioneer Homes

Box 388 10404 - 100 St, Hythe, AB, T0H 2C0
Telephone: (780) 356-3077, Fax: (780) 356-3938

Confidential Medical Report Of Applicant Seeking Admission Into Senior Housing

The information on this medical is being collected under the authority of M.O. H:091/94 under the Alberta Housing Act. The Hythe and Pioneer Homes Board will use this information to verify and assess housing services required by the applicant. The information is protected from public disclosure by sections 38, 40 and 41 of the Freedom of Information and Protection of Privacy Act.

To Attending Physician: **Please complete and return directly to:**
Hythe and District Pioneer Homes
Box 388, 10404 – 100 St
Hythe, AB T0G 2C0
Ph: (780) 356-3077, Fax: (780) 356-3938

Name of Applicant: ______________________ Age: ____________

Examining Physician: ______________________ Date Examined: ____________

Physician Address: ______________________ Physician Phone: ____________

How long has applicant been your patient: ____________

Note to Examining Physician:
This lodge applicant must be able to feed themselves, get to meals and toilet independently. The need for home care, and other services should be arranged prior to admission. Thank you.

1. **Condition:**

Is there any past or present evidence of:

Depression ❑ Yes ❑ No If Yes, ❑ Mild ❑ Medium ❑ Severe

Cognitive Impairment: ❑ Yes ❑ No If Yes, ❑ Mild ❑ Medium ❑ Severe

Alzheimer's Disease: ❑ Yes ❑ No If Yes, ❑ Mild ❑ Medium ❑ Severe

Mental Illness: ❑ Yes ❑ No If Yes, describe: ______________________

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Tendency to Wander: ❑ Yes ❑ No

Uncontrolled Aggressive or Violent Behavior: ❑ Yes ❑ No

Infectious Diseases/Antibiotic Resistant Diseases: ❑ Yes ❑ No If Yes, type: ____________

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Alcohol or Drug Abuse: ❑ Yes ❑ No If Yes, ❑ Past ❑ Present

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2. **Physical Examination:**

Physical Disability: ❑ Yes ❑ No Describe ______________________

Require assistance transferring in and out of bed and to the bathroom: ❑ Yes ❑ No

Mobility Aids: ❑ Cane ❑ White Cane ❑ Walker ❑ Wheel Chair ❑ Scooter

Hearing: ❑ Normal ❑ Impaired ❑ Absent ❑ Hearing Aid

Vision: ❑ Normal ❑ Impaired ❑ Absent ❑ Glasses

Speech: ❑ Normal ❑ Impaired ❑ Absent

Is there communication difficulty? ❑ Yes ❑ No

If yes, due to: ❑ Mental Causes ❑ Deafness ❑ Speech Impediment ❑ Language Barrier

3. **Does your Patient Have the Following:** ❑ Oxygen ❑ Pacemaker

4. **Is your Patient on Home Care:** ❑ Yes ❑ No

5. **Does your Patient Require Medication Assistance?** ❑ Yes ❑ No

6. **Does your Patient have any Allergies or Drug Intolerances?** ❑ Yes ❑ No

If Yes, describe: ______________________

7. **Is Your Patient Diabetic** ❑ Yes ❑ No

Does your patient use Insulin ❑ Yes ❑ No

If Yes, can they self administer the insulin ❑ Yes ❑ No

8. **Does your Patient Require a Special Diet** ❑ Yes: ❑ Diabetic* ❑ Cut-up Food* ❑ No

Please note, there are no dieticians on site, therefore special diets beyond these will have to be managed by the resident.

9. **Is your Patient Urine Continent?** ❑ Yes ❑ No **Is your Patient Bowel Continent?** ❑ Yes ❑ No

10. **TB Screening:** Does your patient's history and/or symptom inquiry indicate a need for TB testing prior to communal living in a seniors lodge. ❑ Yes ❑ No

If ***Yes***, has the referral been made to Public Health ❑ Yes ❑ No

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11. Medical Diagnosis and Other Pertinent Information: ______________________

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Physician Signature:______________________ **Date:**______________