



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

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**

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.

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: _____

Tendency to Wander: Yes No

Uncontrolled Aggressive or Violent Behavior: Yes No

Infectious Diseases/Antibiotic Resistant Diseases: Yes No If Yes, type: _____

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: _____

Physician Signature: _____

Date: _____