green acres
FOUNDATION est.1960

# Medical Report

**I,_____, hereby authorize and instruct Dr. _____ to 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.**

(Applicant) (first name) (last name)

**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? O Yes O No

If "yes", please give particulars_____

Is your patient currently receiving Home Care? O Yes O 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? O Yes O No

If "yes", what type: O Cane O Walker O Manual Wheelchair O Motorized Wheelchair O Scooter

Could this person evacuate from (i.e. use stairs) a multi-storey building independently in the event of an emergency?
O Yes O 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: | ☐ | ☐ | _____ |
| Arthritis: | ☐ | ☐ | _____ |
| Diabetes: | ☐ | ☐ | _____ |
| High Blood Pressure: | ☐ | ☐ | _____ |
| Stroke: | ☐ | ☐ | _____ |
| Incontinence (Bowels): | ☐ | ☐ | If Yes, ☐ Mild ☐ Moderate ☐ Severe |
| Incontinence (Bladder): | ☐ | ☐ | If Yes, ☐ Mild ☐ Moderate ☐ Severe |
| Renal Failure: | ☐ | ☐ | If Yes, ☐ Mild ☐ Moderate ☐ Severe |
| Respiratory Deficiencies: | ☐ | ☐ | _____ |
| Nutritional Deficiencies: | ☐ | ☐ | _____ |
| Depression: | ☐ | ☐ | _____ |
| Cognitive Impairment: | ☐ | ☐ | If Yes, ☐ Mild ☐ Moderate _____ MMSE |
| Alzheimer's Disease: | ☐ | ☐ | If Yes, ☐ Mild ☐ Moderate ☐ Severe |
| Wandering: | ☐ | ☐ | _____ |
| Mental Illness: | ☐ | ☐ | _____ |
| Uncontrolled, Aggressive or Violent Behaviour: | ☐ | ☐ | _____ |
| Parkinson's Disease: | ☐ | ☐ | If Yes, ☐ Mild ☐ Moderate ☐ Severe |
| Drug Sensitivity or Allergies: | ☐ | ☐ | _____ |
| Infectious Diseases: | ☐ | ☐ | If Yes, Type: _____ |
| Alcohol or Drug Abuse: | ☐ | ☐ | If Yes, ☐ Past ☐ Present Details: _____ |
| MRSA or other: | ☐ | ☐ | _____ |

Can your patient:

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