

AGING WITH DIGNITY

Medical Assessment

Must be completed by **your** family physician.

Name	
Current Address	
Phone	
Date of Birth	
Date of Examination	
Place of Examination	
Alberta Health Care Number	
How long has the Applicant been your patient	

Will you be the attending physician when the applicant moves into our facilities?

Yes No

Sex: _____ Height: _____ Weight: _____ Blood Pressure: _____

Drug Sensitivities/Allergies:

Penicillin Other (specify) _____

Sulpha None known

How is the patient's sight? Good Impaired Eyeglasses

How is the patient's hearing? Good Impaired Hearing Aid

How is the patient's speech? Good Impaired

Is there past or present evidence of:

Diabetes: Yes No

High Blood Pressure: Yes No

Stroke: Yes No

Drug or alcohol abuse: Yes No

Heart Disease: Yes No

Cognitive Impairment: Yes No

Infectious diseases: Yes No

Uncontrolled, Aggressive or Violent Behavior: Yes No

Activities of Daily Living

Assistance	None Needed	Supervision	Partial	Full
Washing				
Grooming/Shaving				
Bathing				
Dressing				
Feeding				
Toileting				

Incontinence

	None	Partial	Complete	Intervention	Manages Care
Bladder				<input type="checkbox"/> Catheter	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel				<input type="checkbox"/> Colostomy	<input type="checkbox"/> Yes <input type="checkbox"/> No

Mental Condition

	No	Sometimes	Yes	Comments
Co-operative				
Aggressive				
Wanderer				
Confused				
Dementia				
Depression				
Paranoia				

Has the patient been diagnosed with any mental health condition that may impair his/her ability to manage independently at present or in the near future? Yes No

If yes, please explain:

Has the patient been diagnosed with any physical condition that may impair his/her ability to manage independently at present or in the near future? Yes No

If yes, please explain:

Any chronic diseases which may cause incapacitation to the point of specialized care in the near future? Yes No

If yes, please explain:

Current medications as below or as attached:

Tuberculosis screening assessment of lodge applicants

1. Risk for TB Infection (done at time of application)

- Previous TB disease and/or treatment Yes No
- Born in or prolonged travel in TB endemic country Yes No
- Aboriginal, Metis, Inuit Yes No
- Past health care professional Yes No
- Previous Positive Tuberculin Skin Test (Mantoux) Yes No

2. Risk for Progression from TB Infection to Disease

High Risk

- HIV/AIDS Yes No
- Previous organ transplant or transplant candidate Yes No
- Silicosis (due to occupational exposure to silica dust) Yes No
- End stage/chronic kidney failure/haemodialysis Yes No
- Leukemia, lymphoma, cancer of head and neck Yes No
- Recent TB infection (less than 2 years) Yes No
- Immunosuppressive therapy – radiation, chemotherapy, prolonged corticosteroid use of >15mg/day for >weeks., on TNF Inhibitors Yes No

Lower Risk

- Alcohol and/or IV drug abuse Yes No
- Diabetes - insulin dependent, unstable Yes No
- Gastrectomy Yes No
- Underweight (less than 90% of one's ideal body weight) Yes No

3. Symptom Inquiry

- Persistent cough (more than 3 wks, especially productive) Yes No
- Hemoptysis (blood in sputum) Yes No
- Fever Yes No
- Weight Loss/Loss of appetite Yes No
- Night sweats Yes No
- Fatigue Yes No

Notes: Applicants with risk factors as listed in #1 or #2 above should have their tuberculin status assessed by Public Health at their local Community Health Centre to identify those infected with TB. Those with significant reactions would be referred to the Alberta Health Services Communicable Disease Centre for possible referral to Alberta TB Control re: consideration of preventive TB therapy.

Examining Physician

Physician's Name Printed: _____

Address: _____
(Street/Box #) (Town/City) (Province) (Postal Code)

Physician's Phone Number: _____

Physician's Signature: _____

**DO NOT RETURN THIS FORM TO THE APPLICANT OR APPLICANTS FAMILY.
PLEASE FAX THIS FORM DIRECTLY TO ROTARY HOUSE LODGE AT 780-791-1173**

Authorization for Release of Information

I, _____ hereby authorize and instruct Doctor
_____ to release to Wood Buffalo Housing the information requested, 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.

The personal information in this form is being collected by Wood Buffalo Housing under section
33© of the Freedom of Information and Protection of Privacy Act for the purpose of administering
applications for subsidized housing or rental benefits. If you have any questions regarding the
collection of this information, please contact Management at:
780-791-1160 or by mailing to 10116 Fraser Avenue, Fort McMurray, AB T9H 5E9

Applicant's Signature: _____ **Date:** _____

Witness' Signature: _____ **Date:** _____

THIS MEDICAL REPORT IS VALID FOR 3 MONTHS