# *Bertha Gold Jewish Seniors Residence*

## MEDICAL REPORT

(To be completed by Physician)

**This medical information is required for placement in subsidized seniors housing and is valid for 6 months.**
**Any charge for the completion of this form is the responsibility of the applicant.**
**The completed form may be returned to the patient or sent directly to the address listed in the release below.**

### AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

**I hereby authorize the release of information requested by the housing organization identified below and waive any and all claims against the person or organization releasing this 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.**

**I authorize the release of this information to Bertha Gold Jewish Seniors Residence:**

**1603 – 90Ave SW, Calgary AB T2V 4V7: fax 403-253-8094: email** jcapartments@shaw.ca

**Applicant's Signature: ______________________________________**

**Date (mm/dd/yyyy): ______________________________________**

This personal information is being collected under the authority of the Alberta Housing Act and Alberta Regulation 244/94(Social Housing Accommodation Regulation) and will be used to evaluate the need and eligibility for subsidized senior citizen housing. It is protected by the privacy provisions of the Freedom of Information and Protection of Privacy Act.

| **Patient last name:** | **Patient first name:** |
|---|---|
| **Patient date of birth** (mm/dd/yyyy) | **Date of last exam:** |
| **Health care number:** | |

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**Please provide answers to the following questions and add comments as appropriate:**

| **Has the applicant had any of the following within the past year?** | **In your medical opinion what is the degree of the impairment?** (please circle) | **Provide details of diagnosis and onset** |
|---|---|---|
| **Memory loss** | None Mild Moderate Severe | |
| **Wandering** | None Mild Moderate Severe | |
| **Confusion** | None Mild Moderate Severe | |
| **Aggressive behaviour** | None Mild Moderate Severe | |
| **Violent behaviour** | None Mild Moderate Severe | |
| **Depression** | None Mild Moderate Severe | |
| **Alcoholism/Drug dependency** | None Mild Moderate Severe | |
| **Nutritional deficiencies** | None Mild Moderate Severe | |
| **Incontinence** | None Mild Moderate Severe | |
| **Cardiovascular** | None Mild Moderate Severe | |
| **Respiratory** | None Mild Moderate Severe | |
| **Epilepsy** | None Mild Moderate Severe | |
| **Diabetes** | None Mild Moderate Severe | |
| **Allergies** | None Mild Moderate Severe | |
| **Visual** | None Mild Moderate Severe | |
| **Hearing** | None Mild Moderate Severe | |
| **Mental Illness** | None Mild Moderate Severe | |
| **Other**<br>**(e.g. Communicable Disease)** | | |

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**Does the applicant have?**

| | |
|---|---|
| **Hearing aid** ☐ Yes ☐ No | **Artificial Limb** ☐ Yes ☐ No |
| **Pacemaker** ☐ Yes ☐ No | **Colostomy bag** ☐ Yes ☐ No |
| **Oxygen** ☐ Yes ☐ No | **Walking Aid** ☐ Yes ☐ No |
| **Urinary bag** ☐ Yes ☐ No | **Wheelchair** ☐ Yes ☐ No |
| **Any other Aids to daily living?** ☐ Yes ☐ No | **If yes, please specify:** |

| **Is the applicant able to:** | **Additional comments:** |
|---|---|
| **Administer their own medication?**<br>☐ Yes ☐ No | |
| **Physically function independently in a group setting without putting others at risk, including dressing?**<br>☐ Yes ☐ No | |
| **Safely ambulate?**<br>☐ Yes ☐ No | |
| **Negotiate stairs?**<br>☐ Yes ☐ No | |
| **Maintain appropriate level of personal hygiene?**<br>☐ Yes ☐ No | |
| **Mentally function in a group setting independently without assistance e.g. reminders and prompting?**<br>☐ Yes ☐ No | |
| **Socially fit in with other seniors in a congregate environment?**<br>☐ Yes ☐ No | |

| |
|---|
| **Does the applicant require Home Care Services?** ☐ Yes ☐ No<br>**If yes, what services?** |
| **Does the applicant require other Support Agencies?** ☐ Yes ☐ No<br>**If yes what services?** |
| **Does the applicant have a Psychiatrist or mental health worker?** ☐ Yes ☐ No<br>**If yes, what services?** |

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**Does the applicant smoke?** ☐ Yes ☐ No

**Is this patient a regular patient?** ☐ Yes ☐ No

**Have you seen this patient in the past 2 years?** ☐ Yes ☐ No

**Please list prescribed medications:**

| |
|---|
| |
| |
| |
| |
| |

**General remarks:**

**Name of Physician completing the form:** ______________________________________________

**(Please print clearly)**

**Clinic Address:** ____________________________________________________________________

**Office phone:** ________________________ **Office email/Fax number:**______________________

**Physician signature:** ________________________________________________________________

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