CHINESE ELDERS MANSION Date: ____________

9550-102 AVENUE, EDMONTON, ALBERTA, T5H 4A8
Tel: (780) 429-2146 **Fax: (780) 423-7963**

Confidential Medical Report / Note to the Examining Physician

This medical information form is required by the Chinese Elders Mansion Management in regard to all applicants seeking admission into Self Contained Senior's Apartments. Our facilities are rented only to seniors who are **capable of administering their own personal needs**. Our staff are NOT Qualified or permitted to dispense medication or to provide physical assistance. No meals or housekeeping services are provided in our apartments. There are no special care, nursing care, or special diets available.

Applicants Name: ____________ (Last Name) ____________ (First Name)

Address: ____________ (street) (city) (province) (postal code)

Telephone: (   ) - ____________

Date of Birth: Day/ Month/ /Year

Alberta Health Care: ____________

1) **Do you consider this applicant to be functionally, mentally, and physically independent enough to enter this self contained apartment building?** ☐ Yes ☐ No

Please comment: ____________

2) **Present Findings:**

Oxygen Required	☐ Yes	☐ No
Smoker	☐ Yes	☐ No
Alcoholic	☐ Yes	☐ No

3) **Physical Examination:**

Vision	☐ Good	☐ Impaired	☐ Blind
Hearing	☐ Good	☐ Impaired	☐ Deaf
Mobility	☐ Walks without help		
	☐ Walks with help - please circle one (Walker / Cane / Wheelchair / Scooter)		

Difficulty Communicating? ☐ Yes ☐ No

If yes, is this due to,
☐ Deafness
☐ Speech Difficulty
☐ Language Barrier
☐ Others - please circle one
(stroke/confused/mental illness/   )

4) **Behaviours:**

Socially Appropriate	☐ Yes	☐ No
Cooperative	☐ Yes	☐ No
Aggressive(Verbally/Physically)	☐ Yes	☐ No
Destructive	☐ Yes	☐ No
Confused	☐ Yes	☐ No
Tendencies to wander	☐ Yes	☐ No
Unpleasant habits	☐ Yes	☐ No

If yes, what type of habits? ____________

5) **Is he/she on daily medication?** ☐ Yes ☐ No
If yes, how reliable is the applicant in the practice of taking medication correctly everyday?

____

6) **Does the applicant show any signs of dementia?** ☐ Yes ☐ No

CHINESE ELDERS MANSION
9550-102 AVENUE, EDMONTON, ALBERTA, T5H 4A8
Tel: (780) 429-2146 **Fax: (780) 423-7963**

7) **Any serious injury or fall within the past year?** ☐ Yes ☐ No

If yes, please specify the details and date: ____________________

8) **Severe environmental Allergies:** ☐ Yes ☐ No

If yes, specify: ____________________

9) **Has a geriatric assessment been completed?** ☐ Yes ☐ No

When? ____________ Recommendation? ____________

10) **Is he/she independent in activities of daily living?** ☐ Yes ☐ No

If no, please explain: ____________________

11) **Bowel Incontinence & use of supplies consistently:** ☐ Yes ☐ No ☐ Occasional

12) **If "yes" or "occasional", does the person agree to consistently use continence supplies?** ☐ Yes ☐ No

13) **Bladder Incontinence & use of supplies consistently:** ☐ Yes ☐ No ☐ Occasional

14) **If "yes" or "occasional", does the person agree to consistently use continence supplies?** ☐ Yes ☐ No

15) **How long has the applicant been your patient?** ____________________

16) **Will you be the attending physician when the applicant moves into our building?** ☐ Yes ☐ No

Physician's Name:

Address: ____________________

Tel: ____________________

Signature: ____________________

Date of Examination: ____________________

Authorization for Release of Information from the Medical Report:

I,____________________ **(applicant)** hereby authorize and instruct ____________________**(Doctor name)** to release to the Chinese Elders Mansion 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.

I understand that this personal information is being collected in accordance with the Freedom of Information and Protection of Privacy Act (FIOP) and is protected by the privacy provisions of the FOIP Act, and I consent to said collection.

Applicant's Signature: ____________________ Date: ____________

Witness's Signature: ____________________ Date: ____________