DRUMHELLER & DISTRICT SENIORS FOUNDATION

696 – 6 Ave E. Drumheller, Alberta T0J 0Y5 403-823-3290 Fax: 403-823-3777

Medical Examination Report
Drumheller & District Seniors Foundation
Self-Contained

Applicant Name: _____ Examination Date: _____

Address: _____ Telephone No. _____

Date of Birth: _____ Height: _____ Weight: _____

PLEASE NOTE:
THIS REPORT CANNOT BE ACCEPTED IF IT IS NOT COMPLETELY FILLED OUT.

APPLICANTS AUTHORIZATION

I hereby, authorize the sharing of any records or knowledge of my health between any Physician, Medical Clinic, Home Care, Hospital and the Drumheller & District Seniors Foundation.

DATE: _____ **SIGNATURE: _____**

MENTAL CONDITION
____Normal
____Diagnosis of Dementia
____Mild
____Moderate
____Severe
____History of Delirium
____Delusions
____Hallucinations
____ Alcoholism
____ Drug Abuse

BEHAVIORS
____ Normal
____ Emotionally unstable
____ Easily angered
____ Verbally abusive
____ Physically abusive
____ Wandering
____ Hoarding

MOOD
____Normal
____Depression
____Withdrawn / apathetic

PHYSICAL CONDITION

Speech	____ Normal	____ Impaired	____ Absent
Vision	____ Normal	____ Impaired	____ Absent
Hearing	____ Normal	____ Impaired	____ Absent
Glasses	____ Yes	____ No	
Hearing Aid	____ Yes	____ No	

____ Obesity ____ Arthritis ____ Heart Problem ____ Lung Condition
____ High Blood Pressure ____ Low Blood Pressure

Other: (Please explain)

_____

_____

MOBILITY

__ Independent __ Walking Aid __ Wheelchair

Comments: _____
_____
_____

DEFECTS

__ Arms __ Hands __ Legs __ Feet __ Joints __ Body

Comments:_____
_____
_____

CARE REQUIREMENTS

__ Dresses self
__ Does own grooming
__ Bathes self
__ Feeds self
__ Manages own medications
__ Continent of urine
__ Continent of bowels

DIET

__ Regular __ Low salt __ Low fat __ Diabetic __ Other: (please explain)

_____
_____
_____

MEDICATIONS: **ALLERGIES:**

_____
_____
_____
_____

Does applicant require Home Care Services? ____ Yes ___ No
If yes, what services: _____
_____
_____

Is applicant suffering from any chronic diseases which require:
Special Care? _____ Medical treatment? _____
Comments:
_____
_____
_____

Please comment on any idiosyncrasies, sleeping patterns, personal hygiene

_____
_____
_____
_____

Any further remarks that may be helpful in evaluating the applicant

_____
_____
_____
_____

SIGNATURE OF PHYSICIAN: _____
PRINTED SIGNATURE: _____
COMPLETE ADDRESS:_____
TELEPHONE NO.: _____

This information is being collected under the authority of the Freedom of Information and Protection of Privacy Act 33(C).
Any questions or concerns should be directed to:
Jenny Krystoff, CAO, 696 - 6th Avenue East Drumheller, Alberta T0J 0Y5
Telephone: (403) 823-3290 ext 225