SUNSHINE LODGE Where Friends Become Family! HILLVIEW LODGE
DRUMHELLER DISTRICT SENIORS FOUNDATION
698 6th Ave. E. Drumheller, AB T0J 0Y5 (403)823-3290 FX (403)823-3777

LODGE APPLICATION MEDICAL EXAMINATION REPORT

PLEASE NOTE: THIS DOCUMENT MUST BE FULLY COMPLETED BY A PHYSICIAN PRIOR TO PROCESSING

Dear Health Care Provider:

As part of the application process for Sunshine Lodge, a prospective resident is required to provide a current assessment of their ability to independently manage their daily living. Functional Assessment may also be required in a case where it is believed a resident's needs may have changed over time.

The information requested in this form is to ensure that Sunshine Lodge's supports and services align with the applicant's/resident's needs.

Please complete the questionnaire in full. Please be aware that Sunshine Lodge is a non-medical senior's lodge. Residents may access health supports through Assisted Living Alberta Home Care and/or through arrangements they have with private health providers.

Thank you in advance for completing this questionnaire in its entirety, including signing the document.

If you have any questions regarding the information contained in this section of our application, please feel free to contact Sunshine Lodge at 403-823-3290.

This medical information is required by **Drumheller District Seniors Foundation** for all applicants wishing to obtain residency in the **Sunshine Lodge** program. Please ensure that a **physician** completes all required sections.

Any cost associated with the completion of this form is the responsibility of the applicant

SUNSHINE LODGE Where Friends Become Family! HILLVIEW LODGE
DRUMHELLER DISTRICT SENIORS FOUNDATION
698 6th Ave. E. Drumheller, AB T0J 0Y5 (403)823-3290 FX (403)823-3777

Consent to the Disclosure of Individual Identifying Health Information (Health Authority)

I,_____, authorize the attached Medical
Applicant Name

Examination Report individually identifying myself to be disclosed by_____,
Physician's Name

in accordance with section 34 of the Health Information Act, to Sunshine Lodge, for the following purpose(s): Application & Admission Process or Eligibility Reassessment: I understand that this information will be kept confidential and will be used only in my best interests for assessing my health and social needs, for planning services to meet those needs, and for determining appropriate housing for me. I understand that under section 58 of the Health Information Act (HIA), my express wishes must be considered and I have the right to indicate any portion of my health information that I wish to be kept confidential by my Physician and not disclosed to others.

I understand the risks and/or benefits that are associated with disclosing or not disclosing my information. I release Sunshine Lodge, its employees and agents, from all claims which may arise as a result of the release of the information. This authorization shall be valid during the time in which I am an applicant and/or resident with Sunshine Lodge and may only be terminated at an earlier date by myself in writing.

I am aware that I have the right to revoke a release of information to the above noted persons or organizations at any time in writing to Sunshine Lodge.

SIGN HERE X_____

Signature of Applicant Date

_____

Signature of Witness Print Witness' Full Name

CANCEL	**Please complete this section only if you would like to cancel your consent.** I,_____, cancel this permission. I understand that some action may have been taken prior to cancellation. Applicant Signature: _____ Witness:_____ Date signed:_____/_____/_____ M D Y

SUNSHINE LODGE Where Friends Become Family! HILLVIEW LODGE
DRUMHELLER DISTRICT SENIORS FOUNDATION
698 6th Ave. E. Drumheller, AB T0J 0Y5 (403)823-3290 FX (403)823-3777

APPLICANT NAME: _____ EXAMINATION DATE: _____

ADDRESS: _____ TELEPHONE NO: _____

_____

DATE OF BIRTH: _____ WEIGHT: _____ HEIGHT: _____

SEX: ☐ Male ☐ Female_____ AHC #: _____

PREFERRED PHARMACY: _____

Mental Condition
- □ Normal
- □ Periods of Confusion
- □ Forgetfulness
- □ Persistent Confusion, Disorientation
- □ Hallucinations, Delusions
- □ Paranoia

Behavior
- □ Normal
- □ Hoarding/Rummaging
- □ Emotionally Unstable, If Yes: _____
- □ Withdrawn, Apathetic, If Yes: _____
- □ Wanders, Elopement
- □ Noisy, disturbing to others
- □ Aggression, If Yes: _____

Physical Condition

Speech	□ Normal	□ Impaired	□ Absent
Vision	□ Normal	□ Impaired	□ Absent
Glasses	□ Yes	□ No	
Hearing	□ Normal	□ Impaired	□ Absent
Hearing Aid	□ Yes	□ No	
Denture Status	□ Dentures	□ Own Teeth	□ Regular Dental Visits: Y/N
Sleep Pattern	□ Normal	□ Problem _____	

Mobility

□ Independent □ Cane □ Walker □ Wheelchair (not allowed in lodge)

Diet

☐ Regular ☐ Low salt ☐ Low fat
☐ Diabetic ☐ Celiac ☐ Renal
☐ Other: _____
☐ Food Allergies: _____

Is there evidence of past or present abnormality of? If yes, provide details

Skin Condition	☐ Yes	☐ No	_____
Cardiovascular System	☐ Yes	☐ No	_____
Respiratory System	☐ Yes	☐ No	_____
Gastrointestinal System	☐ Yes	☐ No	_____
Musculoskeletal System	☐ Yes	☐ No	_____
Nervous System	☐ Yes	☐ No	_____
Genital Urinary Conditions	☐ Yes	☐ No	_____
Mental Health Conditions	☐ Yes	☐ No	_____
Infectious Disease	☐ Yes	☐ No	_____
Dementia	☐ Yes	☐ No	_____
Chest X-Ray	☐ Yes	☐ No Date: _____	Results: _____

Activities of Daily Living

Feeds Self	☐ Yes	☐ No	Bathes Self	☐ Yes	☐ No
Dresses Self	☐ Yes	☐ No	Continent of bowels	☐ Yes	☐ No
Does own grooming	☐ Yes	☐ No	Continent of urine	☐ Yes	☐ No

Additional Pertinent History

Alcohol /Drug Abuse	☐ Yes	☐ No Treatments? _____			
Tobacco Use	☐ Yes	☐ No	C. Difficile	☐ Yes	☐ No
MRSA	☐ Yes	☐ No	VRE	☐ Yes	☐ No

Medications

Manages own medications.	☐ Yes	☐ No
Is patient able to acquire and administer medications on their own?	☐ Yes	☐ No
Does the patient require their medications to be in dosettes/blister pack?	☐ Yes	☐ No
Does the patient require assistance in taking their medications safely?	☐ Yes	☐ No
Does the patient receive a yearly flu shot? Last shot (MM/YY) _____	☐ Yes	☐ No

Medical Allergies:_____
List of Medications: _____
_____
_____
_____

Does this applicant have a Goals of Care/Green Sleeve? ☐ Yes ☐ No

Home Care Services

Does the applicant require or receive Home Care Services? ☐ Yes ☐ No

If Yes, what services:_____

Does this applicant have any respiratory concerns? Yes ☐ No ☐

If yes, please explain

_____

_____

_____

Does this applicant have any gastrointestinal concerns? Yes ☐ No ☐

If yes, please explain

_____

_____

_____

Does this applicant have any urinary and/or bowel concerns? Yes ☐ No ☐

If yes, please explain

_____

_____

_____

Does this applicant have any history of addictions that impact their health?

Yes ☐ No ☐

If yes, please explain how this applicant is managing their addiction.

_____

_____

_____

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

If yes, please explain

_____

_____

_____

Has this applicant been hospitalized for a chronic condition in the past six months? Yes ☐ No ☐

If yes, please explain

_____

_____

_____

Does this applicant have any communicable diseases that would jeopardize the health of other vulnerable seniors living in the building? Yes ☐ No ☐

If yes, please explain

_____

_____

_____

Is the applicant known to have a history of falls? Yes ☐ No ☐

If yes, please explain

_____

_____

_____

Is the applicant known to have occurrences of wandering or significant confusion?

Yes ☐ No ☐

If yes, please explain

_____

_____

_____

Does the applicant show any signs of memory loss? Yes ☐ No ☐

If yes, please explain and ATTACH a copy of MMSE, MOCA, or SLUMS that was completed (within the last 60 days)

_____

_____

_____

Has the applicant been diagnosed with any mental health condition that may impair their ability to manage independently at present or in the near future? Yes ☐ No ☐

If yes, please explain

_____

_____

_____

Residents must be able to manage their daily needs and activities, within a congregate setting. Services provided include dining, weekly housekeeping, maintenance, and leisure programs and 24-hour employees on-site. Residents must be able to ambulate to dining room 3x/day.

Is this applicant capable of functioning independently in this setting? Yes ☐ No ☐

If no, please explain

_____

_____

Would the applicant be more appropriately accommodated in a site with a higher level of care than Sunshine Lodge, that offers 24-hour health/medical support? Yes ☐ No ☐

If yes, please explain

_____

_____

_____

This assessment is valid for six (6) months only. The applicant/resident is responsible for notifying Silvera for Seniors if their health circumstances change, affecting the validity of this application.

Health Care Provider Signature *Physician	Date
Printed Name	Name of Medical Clinic

After completion please return to applicant, OR Forward to:

Drumheller & District Seniors Foundation

698 6th Ave. E. Drumheller, AB T0J 0Y5

Phone: (403)823-3290, FAX: (403)823-3777

Email: residentmanager@ddsf.ca

This application contains your personal information, which is being collected under 4(c) and 5(l)(k)(i) of the Protection of Privacy Act (POPA) to be used to determine eligibility of applications, needs and allocation within our Seniors Housing programs. For questions about the collection, use, or safety safeguards of your personal information, contact the DDSF Privacy Officer – Melanie Graff at 403-823-3290, ext 224 or finance@ddsf.ca.