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 ☐
Stroke: Yes ☐ No ☐
Heart Disease: Yes ☐ No ☐
Infectious diseases: Yes ☐ No ☐
High Blood Pressure: Yes ☐ No ☐
Drug or alcohol abuse: Yes ☐ No ☐
Cognitive Impairment: 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				☐ Catheter	☐ Yes ☐ No
Bowel				☐ Colostomy	☐ Yes ☐ 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: _____

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.

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

Applicant's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____

THIS MEDICAL REPORT IS VALID FOR 3 MONTHS