



The information on this form is collected under the authority of the Alberta Housing Act and is in accordance with Alberta's Freedom of Information and Protection of Privacy Act. This information will be used to determine and verify the client's eligibility under Social Housing Accommodation Regulations.

TO: ATTENDING PHYSICIAN MEDICAL INFORMATION for SELF-CONTAINED HOUSING

- A. This medical information form is required by Rocky View Foundation, Self-Contained Housing in regards to the Applicant/Tenant seeking or maintaining subsidized housing.
- B. Any charge for the completion of this form is the responsibility of the Applicant.
- C. Please **Mail, Fax or Email this form directly to:**

Rocky View Foundation
Self-Contained Housing
#103, 58 Gateway Dr. NE. Airdrie, AB. T4B 0J6
Fax: 403.945.9753 Email: sch@rockyviewfoundation.org

AUTHORIZATION FOR RELEASE OF INFORMATION FROM THE MEDICAL REPORT:

I _____ hereby authorize any Physician, Medical Clinic Hospital or other person that has any records or knowledge of my health to provide full information.

Date: _____

Signature of Applicant/Tenant

Witness: _____

PLEASE PRINT

Last Name: _____ First Name: _____

Date of Birth: _____ Date of Last Examination: _____

How long has the applicant been your patient? _____

Our housing consists of self-contained apartments equipped with kitchen and bathroom facilities. The Applicant must be mentally and physically able to maintain him/her self, including cooking, cleaning, personal hygiene, etc. **Given this information, is your patient independent enough to:**

- | | | | |
|---|------------------------------|-----------------------------|----------------------------------|
| 1. Physically manage all personal care? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 2. Maintain an appropriate level of personal hygiene? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 3. Socially fit in with other seniors? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 4. Administer his/her own medication? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 5. Have the mobility to walk a city block (200m)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 6. Is the applicant receiving Home Care? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

If YES, how many hours per week and for what types of service? _____

Are there other support agencies involved? _____

Is there any past or present evidence of:	No	Yes	If YES, give particulars (Please attach additional information if required)
Depression			
Cognitive Impairment			If yes, <input type="checkbox"/> Mild <input type="checkbox"/> Medium <input type="checkbox"/> Severe
Dementia and/or Alzheimer's Disease			If yes, <input type="checkbox"/> Mild <input type="checkbox"/> Medium <input type="checkbox"/> Severe
Mental Illness			
Uncontrolled Aggressive or Violent behavior			
Infectious Diseases			If yes, type:
Alcohol and/or Drug Abuse			If yes, <input type="checkbox"/> Past <input type="checkbox"/> Present Details:
Smoking			If yes, how many per day?

Does the Applicant use any of the following?	Yes	No
Hearing Aid	<input type="checkbox"/>	<input type="checkbox"/>
Oxygen	<input type="checkbox"/>	<input type="checkbox"/>
Mobility Aids: _____	<input type="checkbox"/>	<input type="checkbox"/>

In your professional opinion, this applicant can perform all tasks outlined on page 1 of this medical information sheet and has no issues being able to live independently. Yes No

General Remarks and other pertinent information: _____

Name and Address of Physician completing medical information: Please stamp

Name: _____

Clinic Address: _____

Clinic Phone #: _____

Clinic Fax #: _____

Signature: _____

Date: _____