Rocky View Foundation

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 PHYSCIAN **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 Drive 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?	☐ Yes	☐ No	☐ Unknown
2.	Maintain an appropriate level of personal hygiene?	☐ Yes	☐ No	☐ Unknown
3.	Socially fit in with other seniors?	☐ Yes	☐ No	☐ Unknown
4.	Administer his/her own medication?	☐ Yes	☐ No	☐ Unknown
5.	Have the mobility to walk a city block?	☐ Yes	☐ No	☐ Unknown

Is the Applicant receiving Home Care? ☐ Yes ☐ No ☐ Unknown

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

_____

Are there other support agencies involved? _____

Rocky View Foundation

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, ☐Mild ☐Medium ☐Severe
Alzheimer's Disease			If yes, ☐Mild ☐Medium ☐Severe
Mental Illness			
Uncontrolled Aggressive or Violent behavior			
Infectious Diseases			If yes, type:
Alcohol or Drug Abuse			If yes, ☐Past ☐Present Details:

Does the Applicant use any of the following?	Yes	No
Hearing Aid	☐	☐
Oxygen	☐	☐
Mobility Aids:_____	☐	☐

General Remarks and other pertinent information: _____

_____

_____

Name and Address of Physician completing medical information:

Name: _____ Clinic Address:_____

Clinic Phone #: _____ _____

Clinic Fax #: _____ _____

Signature: _____ Date: _____