

# Medical exam report

We require all applicants applying to live in a seniors' lodge to provide a current medical exam report with their application. Take this form to your family doctor, have them fill out the required information and sign it. Please note that you are responsible for any costs related to the medical exam report.

**Thank you, Doctor, for taking the time to fill out this form. This medical exam report will help us determine whether our seniors independent or supportive lodge would be a suitable fit for the individual listed below.**

**If you have any questions, please call us at 780-963-2149 or fax 780-591-0031.**

## Individual consent to release medical information

First and last name	Date (yyyy-mm-dd)
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I authorize the release of the following medical information to Meridian Housing Foundation.

Individual signature	Date (yyyy-mm-dd)
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## Medical information

Does the individual:

<p><b>Self-care</b></p> <p>Maintain their personal hygiene? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Control urination? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Control bowel movements? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Manage a colostomy independently? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>Independence</b></p> <p>Capable of light house keeping? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Able to prepare their own meals? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Show signs of dementia? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have difficulties communicating? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Require home care services? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>Mobility</b></p> <p>Walk without assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Walk with assistance of mobility aids? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Use a wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If they use a wheelchair, can they transfer unassisted? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>Dietary</b></p> <p>Have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have food allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
List allergies	

Health history/Comments
<p>Assessment</p> <p>Do you believe this individual is mentally and physically capable of taking care of themselves in a communal living environment with only limited support and home care available? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

**Doctor information**

Doctor name (printed)	No. years individual under your care
Specialization	Provincial license no.
Clinic name and address	Clinic phone

**Doctor declaration**

I confirm that the information in this document is accurate and complete to the best of my knowledge.

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Doctor signature	Date (yyyy-mm-dd)
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The personal information collected through this application are for the purposes of managing, monitoring or administering Meridian Housing Foundation's housing programs. This collection is authorized by section 4 (c) of the *Protection of Privacy Act*. For questions about the collection of personal information, contact the privacy officer at [privacy@meridianfoundation.ca](mailto:privacy@meridianfoundation.ca).