LAMONT HEALTH CARE CENTRE

5216 53 Street, PO Box 479

Lamont AB TOB 2RO

Phone: 780-895-2211 FAX: 780-895-7305

APPLICATION FOR ADMISSION TO ASSISTED LIVING – APPENDIX I

APPLICANT IDENTIFICATION (please print)				
LAST NAME:	FIRST:			MIDDLE:
ADDRESS:	CITY:	PROVINCE:		POSTAL CODE:
TELEPHONE (HOME):	TELEPHONE (CELL):	E-MAIL ADDRESS:		
DATE OF BIRTH:	PLACE:	AGE:	SEX:	MARITIAL STATUS:

IDENTIFICATION NUMBER(S):	
AHCIP	ALBERTA BLUE CROSS
OLD AGE SECURITY	SOCIAL INSURANCE NUMBER

NEXT OF KIN:		**EMERGENCY CONTACT:**	
NAME:		NAME:	
ADDRESS OF NEXT OF KIN:		ADDRESS OF EMERGENCY CONTACT:	
TELEPHONE (HOME):	TELEPHONE CELL):	TELEPHONE (HOME):	TELEPHONE (CELL):

NAME OF ALTERNATE DECISION MAKER:
NAME: PHONE:

NAME OF EXECUTOR OF ESTATE OR RESPONSIBLE AGENT:
NAME: PHONE:

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PHYSICIAN DATA (please print)			
PRIMARY PHYSICIAN:		OTHER PHYSICIAN:	
TELEPHONE (BUSINESS):		TELEPHONE (BUSINESS):	
DATE OF APPLICANTS LAST VISIT:		DATE OF APPLICANTS LAST VISIT:	
CONSENT FORM:			
I, hereby agree to admission and accept responsibility for payment of services to the Lamont Health Care Centre.			
Date:	**Applicant Signature:**		
	Applicant Name: (Print)		
	Witness Signature:		
	Witness Name: (Print)		
Office Use Only:			
Date of Admission:	Admitted From:		Room Number:
Charges:	Room:	Laundry:	Food Services:
Parking:		Miscellaneous:	
Date of Discharge:	Reason		

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MEDICAL ASSESSMENT

This medical information form is required by the **Lamont Health Care Centre** in regard to all applicants seeking admission into:

THE ASSISTED LIVING

APPLICANT IDENTIFICATION:

Name: _____ Date of Examination: _____

Address: _____ Telephone: _____

Authorization by applicant to allow physician to release medical information to the Lamont Health Care Centre.

Applicant Signature: _____ Date: _____

NOTE TO THE EXAMINING PHYSICIAN

"The purpose of the Assisted Living Project is to provide affordable accommodation for senior citizens and other persons who are functionality independent with the assistance available through existing community-based health services.

Examining Physician (Please Print) _____

Address: _____

Telephone: _____

How long has the applicant been your patient? _____

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PHYSICAL EXAMINATION

Sight: Good _____ Impaired _____

Hearing: Good _____ Impaired _____

Mobility: Walks without help _____

Walks with help _____

Uses Wheelchair _____

Is there a communication difficulty? YES ____ NO ____

If 'Yes" is this due to: Mental Cause? ____

Deafness? ____

Speech Difficulty? ____

Language Barrier? ____

Medical Diagnosis:

_____

_____

_____

History:

_____

_____

_____

Positive Findings:

_____

_____

Medications:

_____

_____

_____

Allergies or Drug Intolerance:

_____

_____

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ACTIVITIES OF DAILY LIFE

Assistance Needed	Full	Partial	None	Supervision Only
Washing Face and Hands	____	____	____	____
Grooming, Shaving	____	____	____	____
Dressing	____	____	____	____
Bathing	____	____	____	____
Feeding	____	____	____	____
Toileting	____	____	____	____

	Catheter	Complete	Partial	None	Occasional
Bladder Incontinence	____	____	____	____	___
Bowel Incontinence	____	____	____	____	___

MENTAL CONDITIONS

		Yes	At Times	No
Is he/she	Co-operative?	____	____	____
	Aggressive?	____	____	____
	Confused?	____	____	____
	Destructive?	____	____	____
Are there tenancies to wander?		____	____	____
Unpleasant habits?		____	____	____

Does the applicant have a Personal Directive? YES ____ NO ____
(If No: Potential Residents are advised that a Personal Directive is required).

Does the applicant show any signs of Dementia? YES ____ NO ____

If so, to what degree: _____

Do you consider this applicant to be suitable mentally and physically to look after himself/herself in the Assisted Living Morley Young Manor? YES ____ NO ____

DOCTORS SIGNATURE DATE

NOTE: Any charge for the completion of this form is the responsibility of the applicant.

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Please return to the **Executive Director**
Lamont Health Care Centre
P.O. Box 479
Lamont, AB T0B 2R0