LAMONT COUNTY HOUSING FOUNDATION
APPLICATION FOR ADMISSION
Box 120, Lamont, Alberta TOB 2R0

	Beaverhill Pioneer Lodge PH: 780-895-2573 Fax: 780-895-2900 Lamont, AB TOB 2RO	Father Filas Manor PH: 780-764-3013 Fax: 780-764-2056 Mundare, AB T0B 3H0

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	
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):

APPLICATION REQUIRES CURRENT NOTICE OF ASSESSMENT

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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:

DATE OF APPLICATION:	
APPLICATION ACCEPTED BY:	

CONSENT FORM:

I, hereby agree to admission and accept responsibility for payment of services to the Lamont County Housing Foundation.

Date:	**Applicant Signature:**
	Applicant Name: (Print)
	Witness Signature:
	Witness Name: (Print)

Office Use Only:

Date of Admission:	Lodge Name:	Admitted From:	Room Number:
Charges:	Room:	Laundry:	Electricity:
Medication Administration:		Locker Number:	
Date of Discharge:	Reason		

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LAMONT COUNTY HOUSING FOUNATION - MEDICAL ASSESSMENT

This medical information form is required by the **Lamont County Housing Foundation** in regard to all applicants seeking admission into:

LODGE: _____

Address: _____ Telephone: _____

APPLICANT IDENTIFICATION:

Name: _____ Date of Examination: _____

Address: _____ Telephone: _____

NOTE TO THE EXAMINING PHYSICIAN

"The purpose of the Lodge is to provide affordable room and board for senior citizens who are functionally independent with the assistance available through existing community-based services and who would not otherwise be more appropriately provided for in a health care facility."

Examining Physician (Please Print) _____

Address: _____

Telephone: _____

How long has the applicant been your patient? _____

LAMONT COUNTY HOUSING FOUNDATION - MEDICAL ASSESSMENT

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:

_____
_____

LAMONT COUNTY HOUSING FOUNDATION - MEDICAL ASSESSMENT

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 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 him/herself in the Lodge where no health care is available? YES ____ NO ____

DOCTORS SIGNATURE DATE

NOTE: Any charge for the completion of this form is the responsibility of the applicant. Please return to the Lodge Manager at the above address.

MEDICAL RES 02/94