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

| | | |
|---|---|---|
| | **Beaverhill Pioneer Lodge**<br>**Phone: 780-895-2573**<br>**Fax: 780-895-2900**<br>**Lamont, AB TOB 2RO** | **Father Filas Manor**<br>**Phone: 780-764-3013**<br>**Fax: 780-764-2056**<br>**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): |
| Email ADDRESS | | | |

**APPLICATION REQUIRES CURRENT CRA NOTICE OF ASSESSMENT**

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**PHYSICIAN DATA** (please print)

| | |
|---|---|
| PRIMARY PHYSICIAN: | OTHER PHYSICIAN: |
| TELEPHONE (BUSINESS): | TELEPHONE (BUSINESS):: |
| DATE OF APPLICANT'S LAST VISIT: | DATE OF APPLICANT'S 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 | | | |

## LAMONT COUNTY HOUSING FOUNDATION

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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: _____

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**APPLICANT IDENTIFICATION:**

**Name:** _____ **Date of Examination:** _____

**Address:** _____ **Telephone:** _____

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### 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

Revised Nov 2018