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
November 1997
November 2008
Revised May 2014

APPLICANT IDENTIFICATION

Name of Resident Telephone Number

Address

Date of Birth Place Age Sex Marital Status

IDENTIFICATION NUMBER(S)

AHCIP Alberta Blue Cross

Old Age Security Social Insurance Number

NEXT OF KIN **EMERGENCY CONTACT**

Name Name

Address Address

Telephone Number Address

PHYSICIAN DATA

Primary Physician _____ Other Physician _____

Business Phone _____ Business Phone _____

Date of Applicant's Last Visit _____ Date of Applicant's Last Visit _____

CONSENT FORM

I hereby agree to admission and accept responsibility for payment of services to the Lamont Health Care Centre.

Date: _____ Signature: _____

Name (print): _____

Witness: _____

Name (print): _____

OFFICE USE ONLY

Date of Admission: _____ From: _____

Room Number: _____

Charges: Room _____ Laundry _____ Food Services _____

Parking _____ Miscellaneous _____

Date of Discharge: _____ **Reason:** _____

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MEDICAL ASSESSMENT

This medical information 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 functionally 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? _____

PHYSICAL EXAMINATION

Sight: Good _____ Impaired _____
Hearing: Good _____ Impaired _____
Mobility: Walks without assistance _____
Walks with assistance _____
Uses Wheelchair _____

Is there a communication difficulty? _____

If '**yes**' is this due to: Mental Cause ___
Deafness ___
Speech Difficulty ___
Language Barrier ___

Medical Diagnosis:

_____
_____

History:

_____
_____

Positive Findings:

_____

_____

Medications:

_____
_____
_____

Allergies or Drug Intolerance:

_____
_____

APPLICATION FOR ADMISSION TO ASSISTED LIVING
MEDICAL ASSESSMENT

Name:

ACTIVITIES OF DAILY LIFE

Assistance Needed	**Full**	**Partial**	**None**	**Supervision Only**
Washing Face & 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 tendencies 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?	___	___	___

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

Please circle one

_____ _____

Doctor's Signature Date

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

Please return to the **Executive Director**
Lamont Health Care Centre
P.O. Box 479
LAMONT AB TOB 2RO

July 2010
May 2014