

Bishop O'Byrne Housing for Seniors Association
MEDICAL INFORMATION

To: **Attending Physician:**

- A. This medical information form is required by **Bishop O'Byrne Housing for Senior Citizens** for all Applicants seeking admission into self-contained senior citizens apartments. All information must be current within a six-month time frame.
- B. The form is to supplement other information to determine if the Applicant is physically and mentally able to look after themselves in a self-contained apartment-type complex. All information is confidential and its specific purpose is in accordance with the Freedom of Information & Protection of Privacy Act.
- C. Any charge for the completion of this form is the responsibility of the Applicant. Once the Applicant has signed the Authorization, please do not return the form to the Applicant but mail or fax it directly to:

Bishop O'Byrne Housing for Seniors Assn.
510 - 1540 Northmount Drive NW
Calgary, Alta.
T2L 0G6
Fax: 255-8468

AUTHORIZATION

I hereby authorize any Physician, Medical Clinic, Hospital or other person that has any records or knowledge of my health to provide full information to **Bishop O'Byrne Housing for Senior Citizens** or any authority acting on their behalf.

Signature of Applicant _____ Date _____

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Name of Applicant: _____
Print

How long has the applicant been your patient? _____

Date of most recent medical appointment: _____

Does the Applicant:

1. Show any signs of dementia? Yes _____ No _____

Explanation: _____

2. Have any history of alcohol or substance abuse? Yes _____ No _____

Explanation: _____

3. Have any diagnosis which indicates a deteriorating physical or mental health condition that may impair his/her ability to manage independently at present or in the near future? Yes _____ No _____

Explanation: _____

4. Have a history of any violent or aggressive behaviour? Yes _____ No _____

Explanation _____

Do you consider the applicant to be suitable to live in a seniors apartment where no special care is provided?

Mentally: Yes _____ No _____

Physically: Yes _____ No _____

Socially: Yes _____ No _____

Explanation: _____

Please detail any medical information you feel would be important to your patient's application for senior citizen's housing. (We do not provide meal or housekeeping services.) Please also list any serious medical concerns the manager should be aware of.

Signature of Physician: _____ Date: _____

Name of Physician: _____

Please Print

Phone: _____

Address: _____ Postal Code _____

Please Print

This personal information is being collected under the authority of the Alberta Housing Act and Alberta Regulation 244/94 (Social Housing Accommodation Regulation) and will be used to evaluate the need and eligibility for subsidized senior citizen housing. It is protected by the privacy provisions of the Freedom of Information and Protection of Privacy Act.

If you have any questions about the collection contact: FOIP co-coordinator at 263-0947.