

Medical Report for Applicant

CANTERBURY FOUNDATION

8403 - 142 Street Edmonton, Alberta T5R 4L3 Telephone: 483-5361 FAX: 484-0234

(To be completed by your physician) Please print or type

Name: _____ Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone No. _____ Date of Birth: _____ Sex _____

Albera Health # _____ Allergies: _____

List all diagnosis (in order of significance): _____

List all current medication, stating dose, time, indication (include all over the counter medications):

Does Applicant require any treatments? YES NO If so, please detail: _____

Have you noticed any indications, or have concerns re the following?

- | | | | | | |
|---------------------|------------------------------|-----------------------------|----------------------|------------------------------|-----------------------------|
| Falls | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Substance abuse | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Memory | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Judgements/Decisions | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Anxiety | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Depression | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Stress Incontinence | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Incontinence | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Suicide | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Paranoia | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Hallucinations | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Agitation | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Aggression | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Wandering | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

If yes, please explain: _____

Is Applicant on any special diet? YES NO

If so, describe: _____

How long has Applicant been your patient? _____

NAME OF PHYSICIAN: _____ DATE OF EXAM: _____

TELEPHONE NO. _____ ADDRESS: _____

Canterbury Foundation is in compliance with the personal information Alberta protection act. For more information contact the leasing office.