

FELLOWSHIP TOWERS RETIREMENT RESIDENCE

877 Yonge Street, Toronto, Ontario, M4W 3M2 Tel: (416-923-8887) Fax: (416-923-1343)

To be completed by APPLICANT:

MEDICAL APPLICATION

Name: Mr./Mrs./Miss _____

Present Address: _____

Date of Birth _____ / _____ / _____ Postal Code: _____
Day Month Year

Health Card No: Expiry Date: _____

NEXT OF KIN: Name: _____ Relationship: _____

Phone: Home - (_____) _____ Business - (_____) _____

To Be Completed by PHYSICIAN:

Dr. _____ Phone: (_____) _____

Address: _____ Postal Code: _____

How long have you been attending applicant? _____

HISTORY OF PAST HEALTH (Briefly list past operations and significant illness with approximate dates and places of hospitalization).

CONSULTS: Name: _____ Specialty _____
Name: _____ Specialty _____
Name: _____ Specialty _____

PRESENT PHYSICAL CONDITION (Briefly describe history of present illness(s) and date(s) of onset)

OVERALL EXPECTED OUTCOME: Stable ___ Deteriorating ___ Improvement ___ Unknown ___

IS THERE ANY EVIDENCE OF dementia, confusion or personality disorder?

YES ___ NO ___ If YES, please complete attached MMSE

PRESENT MEDICATIONS (with dosage and date of initiation)

IMMUNIZATION RECORD

Mantoux _____ Date _____ Result _____
Pneumovac _____
Flu _____
Tetanus Toxoid _____

ALLERGIES (List all known allergies)

DATE OF MOST RECENT CHEST X-RAY (Please include report) _____

Baseline B/P _____ **Weight** _____ **Height** _____

SPECIAL DIET? YES _____ NO _____ **PLEASE GIVE DETAILS** _____

SMOKER: YES _____ NO _____ EX _____ DATE QUIT _____
ALCOHOL ABUSE _____ CURRENT _____
DRUG ABUSE : PRESCRIPTION _____ RECREATIONAL _____

IS THE APPLICANT ABLE to care for himself/herself without assistance? YES _____ NO _____
If NO, what assistance is required?

IS THERE ANY EVIDENCE of incontinence of urine or stool? YES _____ NO _____
If YES, please give details:

IS THIS PERSON ambulatory without assistance? YES _____ NO _____
If NO, what assistance if needed?

DESCRIBE APPLICANT'S:

Vision: Normal _____ Impaired _____ Blind _____ **Contact lenses ?** YES _____ NO _____
Hearing: Normal _____ Impaired _____ Deaf _____ **Uses a hearing aid?** YES _____ NO _____
Speech: Normal _____ or describe _____
Dentures: Yes _____ No _____

COMMENTS: Please note whether there is anything in your view which might affect the applicant's ability to function in our self-care setting.

Date _____ **Physician's Signature:** _____

I hereby release to Fellowship Towers the above medical information.

Date _____ **Applicant's Signature:** _____