APPLICANT'S MEDICAL FORM

MEDICAL FORM is COMPULSORY for each person wishing to be considered for residency at Canadian Macedonian Place The information supplied will ASSIST the Admissions Committee in its EVALUATION of applicant's request for apartment space at Canadian Macedonian Place and will be held in STRICT CONFIDENCE.

APPLICANT

Last Name: **First Name:** **Age:** **M / F**

HISTORY

Present Medical Problem: ______________________________

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Past Medical History: ______________________________

____

CHECK if positive: CVS_______ Resp._______ GI _______ CNS_______ Others_______

IF POSITIVE, please explain:______________________________

____

Surgery: ______________________________

____

Allergies: ______________________________

____

Date and Place of last X-Ray:

Name of Specialists involved in care of applicant:

PRESENT

Medication & Dosage: ______________________ ______________________

______________________ ______________________ ______________________

HABITS:

Bladder control normal Y / N **Bowel control normal Y / N**

Able to speak normally Y / N **Able to hear conversational voice Y / N**

Able to bathe self Y / N **Able to use toilet facilities Y / N**

Able to see for purpose of ambulation Y / N **Able to dress self Y / N**

Able to feed self Y / N **Walks without assistance Y / N**

Requires cane or other device Y / N **Does person have colostomy Y / N**

Does person have indwelling catheter Y / N

Is this person on a special diet and if so, please specify:____

EXAMINATION:

Height ___________ **Weight** ___________ **Pulse** ___________ **B. P.** ___________ **Skin** ____________

Please list any positive findings of examination:____

MENTAL CONDITION:

Approximately normal ___________________________

Occasional periods of confusion and / or forgetfulness __________________________

Marked confusion and disorientation with brief periods of alertness and proper orientation ________________

Obvious and persistent confusion and disorientation ____

IS APPLICANT LIABLE TO BE A CAUSE OF DISTURBANCE OR TROUBLE TO OTHERS? YES / NO

Please give results of these tests done within the last three month if available!

Hgb. **Urine** **T. B. Test**

DIAGNOSES:	stable	unstable
1.___________________________________	__________________	___________________
2.___________________________________	__________________	___________________
3.___________________________________	__________________	___________________
4.___________________________________	__________________	___________________
5.		

I herby certify that the above is a true statement of my findings to the best of my knowledge and belief:

PHYSICIAN'S NAME: ___________________________________ **DATE:** _______________**TEL:**____________________

ADDRESS: ____ **M.D. Signature:** ____________________________

I will accept responsibility for the medical care of ____________________________________ **while in residency at Canadian Macedonian Place. With this acceptance with responsibility, I agree to provide medical care in accordance with the Ontario Charitable Institutions Act which requires a resident to have a yearly physical. I also agree to provide twenty-four hour medical coverage.**

____**M. D.**