THIS IS A NON-SMOKING BUILDING

A P P L I C A N T'S M E D I C A L F O R M

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: _____

_____

_____

_____

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**
Does person have indwelling catheter	**Y / N**	**Does person have colostomy**	**Y / N**
Are you a Smoker?	**Y / N**	**Requires cane or other device**	**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: _____

Canadian Macedonian Place is an Independent Living Facility of multiple apartments with no medical/nursing assistance. Homecare can be arranged as you deem appropriate. I agree to provide medical care in accordance with the Ontario Charitable Institutions Act which requires a resident to have a yearly physical. I will also continue to provide medical coverage as I have in the past.

_____M. D.