Draft_v1

Holland Christian Homes

Medical **Application** for Independent Living at the Towers

Applicant: Please forward directly to your physician. *Upon completion, return to the address below:*

Holland Christian Homes Inc. *Attention: Admissions Coordinator*
7900 McLaughlin Road South, Brampton, Ontario L6Y 5A7
905 459.3333
905 459.8667 (Fax)

PLEASE PRINT:

Mr./Mrs./Ms./Miss	Surname	Given Name	Age	D.O.B. (m/d/y)
Address	City/Town	Province / Postal Code	Health Card #	

Physician: *Holland Christian Homes Inc. offers self-contained accommodation for Senior Citizens. While there is some provision for supportive services, it is important that the applicant be able to live independently. By answering the questions below, you will help us in assessing the prospective tenant and his/her ability to live in our facility.*

You have attended the patient for _____ years. In what capacity? ◯ Family ◯ Consultant

Will the patient be under your care here? ◯ YES ◯ NO

Medical History/Diagnosis:

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

Activities of Daily Living:

	Independent	Some help	Much help
Dressing			
Grooming			
Bathing			
Toileting			
Housekeeping			
Medication Management			
Cooking			
Shopping			
Money Management			

List all medications currently used: *(Dosage/Frequency)*

.....

.....

.....

.....

.....

.....

.....

.....

You may attach a cumulative patient profile for the diagnosis and medication sections.

Holland Christian Homes

Medical **Application** for Independent Living at the Towers

Functional Inquiry

BP: P: *(regular/irregular)*

Mental Status

Does the patient have any cognitive or psychological impairment which would hamper his/her ability to care for himself/herself in a minimal care setting?

Alert, Lucid	Forgetful	MMSE
Depression	Psychiatric History	

Additional Comments:

Ambulation

Independent	Requires Assistance/Devices
History of Falls	

Additional Comments:

Does the patient have any serious sensory limitations?

◯ Vision	◯ Hearing
◯ Speech	◯ Other

Is the patient on a special diet?

Does the patient have any allergies?

TB Status *(if known)*:	◯ Negative	◯ Positive	Date:	Result *(in mm)*:
Pneumovax:	◯ Yes	◯ No	Date:	Date of Last Td:
Date of last CXR:		Result:		
Date of Last CBC:		Result:		

Additional Comments:

Signature of Physician: Date:

Physician's Name

Address Postal Code

Telephone # Fax #

You may attach a cumulative patient profile for the diagnosis and medication sections.

Holland Christian Homes Inc.
7900 McLaughlin Road South
Brampton, Ontario
L6Y 5A7

Main HCH *(Automated)* 905 463.7002
HCH *(Switchboard)* 905 459.3333

www.hch.ca