

**THE WESTLOCK FOUNDATION**  
**APPLICATION FOR ACCOMMODATION FOR PEMBINA/SMITHFIELD LODGE**  
(please show preference)

ANSWER ALL QUESTIONS (please print clearly)

Date: \_\_\_\_\_

1. Self: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

(surname)

(given name)

Alberta Health Care Number: \_\_\_\_\_

Prefer: (1) Lodge Accommodation: Pembina \_\_\_\_\_

Smithfield: \_\_\_\_\_

(2) Smithfield Supportive Housing: \_\_\_\_\_

(3) Cottage Units \_\_\_\_\_

Do you require a Parking Stall? \_\_\_\_\_

Vehicle Make: \_\_\_\_\_ Year \_\_\_\_\_ License No. \_\_\_\_\_ Color: \_\_\_\_\_

2. Present Address: \_\_\_\_\_

Telephone No.: \_\_\_\_\_

Postal Code: \_\_\_\_\_

(City, Town, Village)

3. Length of Residence in Canada \_\_\_\_\_ In Alberta \_\_\_\_\_ In Westlock \_\_\_\_\_

4. Contacts: 1) Name \_\_\_\_\_ Relationship: \_\_\_\_\_

(in case of emergency)

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_

(City, Town, Village)

Telephone No.: \_\_\_\_\_

2) Name \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_

(City, Town, Village)

Telephone No.: \_\_\_\_\_

3) Name \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_

(City, Town, Village)

Telephone No.: \_\_\_\_\_

\*\*1<sup>st</sup> contact should be person who signs the responsibility form\*\*

5. My reason for wishing to move is \_\_\_\_\_

6. I have designated the following person as my power of attorney: \_\_\_\_\_

7. If you have a will, Executors name: \_\_\_\_\_

**A COPY OF YOUR MOST RECENT NOTICE OF ASSESSMENT/TAX RETURN MUST ACCOMPANY THE APPLICATION FORM ALONG WITH Current Medical Form, Responsibility Form, Health Information Waiver**

**COMPLETE  
AND RETURN  
TO:**

**For Smithfield  
WESTLOCK FOUNDATION  
10203 - 97<sup>TH</sup> STREET  
WESTLOCK, ALBERTA  
T7P 2H1**

**For Pembina  
WESTLOCK FOUNDATION  
10247-104 Street  
WESTLOCK, ALBERTA  
T7P 1V4**

**WESTLOCK FOUNDATION**  
**10203 – 97<sup>th</sup> Street, Westlock, Alberta T7P 2H1**  
**RESIDENT SERVICES MANAGER**

1) at Smithfield: Gayl Weiss /Judy Toronchuk PHONE: 780-349-4123 ext.228 FAX: 780-349-4103  
2) at Pembina: Frauke Perra PHONE 780-349-4123 ext 233 FAX 780-349-4335

CONFIDENTIAL MEDICAL REPORT

(Please Print Clearly)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ Date Examined: \_\_\_\_\_

Examining Physician: \_\_\_\_\_ Address: \_\_\_\_\_

How long has the applicant been your patient? \_\_\_\_\_

**NOTE TO THE EXAMINING PHYSICIAN**

**Our accommodations are NOT staffed to provide physical assistance to tenants and guests. Our Lodges provide meals without special diets and housekeeping service only. All applicants must be capable of otherwise administering to their own personal needs.**

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PHYSICAL EXAMINATION

HT \_\_\_\_\_ WT \_\_\_\_\_ B.P. \_\_\_\_\_ HEMOGLOBIN \_\_\_\_\_ URINALYSIS \_\_\_\_\_

SIGHT: Good \_\_\_\_\_ Impaired \_\_\_\_\_

HEARING: Good \_\_\_\_\_ Impaired \_\_\_\_\_

Mobility: Walks without help \_\_\_\_\_

Walks with help \_\_\_\_\_

Uses wheelchair \_\_\_\_\_

Is there a communication difficulty? \_\_\_\_\_ If yes, is this due to:

Mental causes \_\_\_\_\_ Deafness \_\_\_\_\_ Speech Difficulty \_\_\_\_\_

Language Barrier \_\_\_\_\_

MEDICAL DIAGNOSIS:

HISTORY:

POSITIVE FINDINGS:

MEDICATIONS:

(See Attached)

CONFIDENTIAL MEDICAL REPORT FOR \_\_\_\_\_ (continued)

➤ Have you ever had tuberculosis? YES \_\_\_ NO\_\_\_

Do you have any of the following symptoms:

➤ Productive cough (coughing up phlegm) of more then 4 weeks? YES \_\_\_ NO\_\_\_

➤ Weight loss? YES\_\_\_ NO\_\_\_

➤ Night sweats (fever at night)? YES\_\_\_ NO\_\_\_

➤ Blood in you sputum? YES\_\_\_ NO\_\_\_

ALLERGIES OR DRUG INTOLERANCE: \_\_\_\_\_

ACTIVITIES OF DAILY LIFE	FULL ASSISTANCE	PARTIAL ASSISTANCE	SUPERVISION ONLY	NONE NEEDED	
Washing Face and Hands	_____	_____	_____	_____	
Grooming, Shaving	_____	_____	_____	_____	
Dressing	_____	_____	_____	_____	
Bathing	_____	_____	_____	_____	
Feeding	_____	_____	_____	_____	
Toileting	_____	_____	_____	_____	
	CATHETER	COMPLETE	PARTIAL	OCCASIONAL	NONE
Bladder Incontinence	_____	_____	_____	_____	_____
Bowel Incontinence	_____	_____	_____	_____	_____

MENTAL CONDITION	YES AT TIMES NO				YES AT TIMES NO		
	YES	AT TIMES	NO		YES	AT TIMES	NO
Is he/she co-operative	_____	_____	_____	Confused	_____	_____	_____
Aggressive	_____	_____	_____	Destructive	_____	_____	_____
Are there tendencies to wander	_____	_____	_____	Unpleasant Habits	_____	_____	_____

Has the applicant ever been diagnosed with a mental illness: Yes \_\_\_\_\_ No \_\_\_\_\_

Is the applicant being treated by Mental Health at this time: Yes \_\_\_\_\_ No \_\_\_\_\_

CONFIDENTIAL MEDICAL REPORT FOR \_\_\_\_\_(continued)

Has there ever been substance abuse: Yes \_\_\_\_\_ No \_\_\_\_\_

Does the applicant show any signs of senility? \_\_\_\_\_ If so, to what degree? \_\_\_\_\_

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CHEST X-RAY REPORT \_\_\_\_\_ DATE: \_\_\_\_\_ (PLEASE ATTACH REPORT)

Do you consider this applicant to be suitable mentally and physically to enter a Lodge or Unit where no special care, nursing care, or special diets are available? \_\_\_\_\_

DATE: \_\_\_\_\_

\_\_\_\_\_  
DOCTOR'S SIGNATURE

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
TELEPHONE

**WESTLOCK FOUNDATION**  
*Health Information Waiver*

I, \_\_\_\_\_, authorize the Westlock Foundation to exchange information concerning my health and social needs with the Aspen Regional Health Authority, its agents and employees, health professionals, and any other agency or social service provider.

I understand that this information will be kept confidential and will be used only in my best interest for assessing my health and social needs, for planning services to meet those needs, and for determining appropriate housing for me.

I release the Westlock Foundation, its employees and agents, from all claims, which may arise as a result of the release of the information described above.

This authorization shall be valid during the time that I am resident in Westlock Foundation housing unless terminated at an earlier date by myself in writing.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

WITNESS:

RESIDENT:

\_\_\_\_\_  
Westlock Foundation  
10203-97 Street  
Westlock, Alberta T7P 1V4

\_\_\_\_\_  
(Resident's Signature)

\_\_\_\_\_  
(Witness's signature & address)

\_\_\_\_\_  
(Guardian's signature if applicable)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Westlock Foundation**  
*Responsibility Form*

For \_\_\_\_\_ (Name)

I/We, \_\_\_\_\_,

residing at \_\_\_\_\_, (mailing address)

\_\_\_\_\_ (Telephone number), do hereby agree to be the

person/persons the Westlock Foundation will contact to make appointments for and/or

arrangements for extra care/services that the resident may need while living in

Pembina/Smithfield Facilities.

Signed this \_\_\_\_\_ day of \_\_\_\_\_ (month) in the year \_\_\_\_\_.

\_\_\_\_\_  
(Resident)

\_\_\_\_\_  
(Responsible Relative)

\_\_\_\_\_  
(Resident)

\_\_\_\_\_  
(Responsible Relative)

# WESTLOCK FOUNDATION

## *Personal Information Consent Form*

I, \_\_\_\_\_, authorize the Westlock Foundation to disclose or exchange my  
(Please Print)  
personal information as it relates to my health and/or social needs with the Aspen Regional Health Authority, its agents and employees, health care professionals, and any other agency or social service provider.

Under the privacy guidelines of F.O.I.P.; my personal information will be kept confidential and will only be used for the purpose of assessing my health and social needs, for planning services to meet those needs, and for determining appropriate housing.

Each third party that we intend to disclose personal information has either signed an agreement to protect the information according to our Foundation policy, or has provided a copy of their privacy policy, which we have reviewed and found adequate. Your consent releases the Westlock Foundation, its employees and agents, from all claims, which may arise as a result of the release of information described above.

My personal information shall not be used or disclosed for purposes other than those for which it was collected, except with my consent during the time that I am a resident of Westlock Foundation facilities. My consent may be terminated or withdrawn at any time in writing by myself.

**Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_**

**Resident Name** \_\_\_\_\_  
(Please Print)

**Resident's Signature** \_\_\_\_\_

**Guardian's Signature** \_\_\_\_\_  
(If applicable)

**Witness Name (Must be completed)** \_\_\_\_\_  
(Please Print)

**Westlock Foundation**  
**10247-104 Street**  
**Westlock, Alberta T7P 1V4**

**Witness Signature** \_\_\_\_\_

**Witness Address** \_\_\_\_\_  
\_\_\_\_\_