

THE WESTLOCK FOUNDATION
APPLICATION FOR ACCOMMODATION FOR PEMBINA/SMITHFIELD LODGE
Revised 071411

ANSWER ALL QUESTIONS (please print clearly)

Date: _____

1. Self: _____

Date of Birth: _____

(surname)

(given name)

Alberta Health Care Number: _____

Prefer: Lodge Accommodation (Please mark in order of preference, 1 being the highest:

- | | |
|----------------------|--------------------------|
| 1. Smithfield Lodge | <input type="checkbox"/> |
| 2. Smithfield Suites | <input type="checkbox"/> |
| 3. Pembina Lodge | <input type="checkbox"/> |
| 4. Pembina Suites | <input type="checkbox"/> |

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. **Next of Kin: 1) Name _____ Relationship: _____

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)

If no relatives, please list closest friend

Telephone No.: _____

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 TAX RETURN MUST ACCOMPANY THE APPLICATION FORM

COMPLETE AND
RETURN TO:

WESTLOCK FOUNDATION
10203 – 97TH STREET
WESTLOCK, ALBERTA T7P 2H1

Director of Resident Services
Gayl Weiss
Phone: 349-4123 ext.228
Fax: 349-8249

WESTLOCK FOUNDATION
10203 – 97th Street, Westlock, Alberta T7P 2H1
DIRECTOR OF RESIDENT SERVICES: Gayl Weiss PHONE: 349-4123 ext.228 FAX: 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 than 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
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? _____

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 _____
(Please Print)

Westlock Foundation
10203 – 97 Street
Westlock, Alberta T7P 2H1

Witness Signature _____

Witness Address _____
