



The information on this form is collected under the authority of the Alberta Housing Act and is in accordance with Alberta's Freedom of Information and Protection of Privacy Act. This information will be used to determine and verify the client's eligibility under Social Housing Accommodation Regulations. If you have any questions, you may contact a Property Clerk or the FOIP Co-ordinator at Lethbridge Housing Authority's Business Office: 324-B, Mayor Magrath Drive South, Lethbridge, AB T1J 3L7, Phone (403) 329-0556; Fax (403) 327-3906.

MEDICAL INFORMATION for SOCIAL HOUSING

TO: ATTENDING PHYSICIAN

A. This medical information form is required by Lethbridge Housing in regards to the Applicant/Tenant seeking or maintaining subsidized housing. All information must be current within a 6-month time frame.

B. Any charge for the completion of this form is the responsibility of the Applicant.

C. Please **Mail or Fax this form directly to:**

LETHBRIDGE HOUSING AUTHORITY
324-B, Mayor Magrath Drive South
LETHBRIDGE, AB T1J 3L7
FAX: 403-327-3906

AUTHORIZATION FOR RELEASE OF INFORMATION FROM THE MEDICAL REPORT:

I _____ hereby authorize any Physician, Medical Clinic, Hospital or other person that has any records or knowledge of my health to provide full information.

Date: _____

Signature of Applicant / Tenant

Witness: _____

PLEASE PRINT

Last Name: _____ First Name: _____

Date of Birth: _____ Date of Last Examination: _____

How long has applicant been your patient? _____

Our housing consists of self-contained apartments equipped with kitchen and bathroom facilities. The Applicant must be mentally and physically able to maintain him/her self, including cooking, cleaning, personal hygiene, etc. **Given this information, is your patient independent enough to:**

- 1. Physically manage all personal care? Yes No Unknown
- 2. Maintain an appropriate level of personal hygiene? Yes No Unknown
- 3. Socially fit in with other seniors? Yes No Unknown
- 4. Administer his/her own medication? Yes No Unknown

Is the Applicant currently receiving Home Care? Yes No Unknown

If YES, how many hours per week and for what types of service? _____

Are any other support agencies involved? _____



Is there any past or present evidence of:	NO	YES	If YES, please explain how this impacts the ability to live independently (<i>Please attach additional information if required</i>)
Depression			
Cognitive Impairment			If yes, <input type="checkbox"/> Mild <input type="checkbox"/> Medium <input type="checkbox"/> Severe
Alzheimer's Disease			If yes, <input type="checkbox"/> Mild <input type="checkbox"/> Medium <input type="checkbox"/> Severe
Mental Illness			
Uncontrolled Aggressive or Violent behavior			
Infectious Diseases			If yes, type:
Alcohol or Drug Abuse			If yes, <input type="checkbox"/> Past <input type="checkbox"/> Present Details:

Does the Applicant use any of the following?	Yes	No
Hearing Aid	<input type="checkbox"/>	<input type="checkbox"/>
Oxygen	<input type="checkbox"/>	<input type="checkbox"/>
Mobility Aids: _____	<input type="checkbox"/>	<input type="checkbox"/>

If there is impairment, please describe applicant's ability to live independently and interact with others:

Name and Address of Physician completing medical information:

Name: _____ Clinic Address: _____

Clinic Phone No: _____

Clinic Fax No: _____

Signature: _____ Date: _____

THIS MEDICAL REPORT IS VALID FOR 6 MONTHS