



Seniors Self-Contained Apartments and Seniors Lodge Confidential Medical Report

****Please Read Carefully****

Revised April 2026





Seniors Self-Contained Apartments and Seniors Lodge Confidential Medical Report

		Fax Number	Phone Number
Alpine Summit Seniors Lodge Jasper	Valerie Bartziokas	780-852-4883	780-852-4881
Parkland Lodge Edson	Aubrie Acorn	780-723-7347	780-723-3522
Pine Valley Lodge Hinton	Dawne Pineau	780-865-1403	780-865-7366
Sunshine Place Lodge Evansburg	Natasha Crosby	780-727-2410	780-727-4482
Whispering Pines Lodge Grande Cache	Janine Humby	780-827-5601	780-827-5600
Kikinow Elders Lodge MD of Greenview	Sharon Moberly		780-827-2144
Heritage Court & Heatherwood Manor Edson	Vivian Williams	780-712-7457	780-723-7117
Lion's Sunset Manor Hinton	Sandra Gallimore	780-865-4764	780-865-4762
Pembina 1, 2, & 3, Entwistle Manor Evansburg	Tracey Melnyk	780-727-2029	780-727-2613
Rosewood Manor and Wildrose Villa Wildwood	Tracey Melnyk	780-727-2029	780-727-2613



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Dear Physician,

As part of the application and admission process for The Evergreens Foundation, a prospective resident is required to provide us with a current medical report.

The medical information requested in this form is needed to determine the independence and eligibility of the applicant to live in one of our seniors' facilities. This could be one of our seniors' self-contained apartments or one of our lodges. This information is confidential and is privy only to the Screening Committee members, including the manager of the site.

Please complete the questionnaire in full with all the pertinent information concerning the client. Please be aware that most of our sites have no assistance from Medical Personnel, other than Home Care.

Thank you in advance for completing the medical questionnaire in its entirety. If you have any questions regarding the information contained in the medical section of our application, please feel free to contact the appropriate manager listed on the previous page.

Note: Your patient will be responsible for any costs associated with this medical report

Respectfully,

A handwritten signature in black ink, appearing to read "Kristen Chambers", with a long horizontal flourish extending to the right.

Kristen Chambers, CAO
The Evergreens Foundation
780-865-5444



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Consent to the Disclosure of Individual Identifying Health Information (Health Authority)

I, _____, authorize the attached Medical Examination Report individually identifying myself to be disclosed by Dr. _____, in accordance with Section 34 of the *Health Information Act*, TO The Evergreens Foundation, for the following purpose(s);

- Application & Admission Process

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 understand that under Section 58(2) of the *Health Information Act (HIA)* my express wishes must be considered and I have the right to indicate any portion of my health information that I wish to be kept confidential by my physician and not disclosed to others. (See components of HIA as quoted on the following page)

I also understand the risks and/or benefits that are associated with disclosing or not disclosing my information.

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

This authorization shall be valid during the time in which I am an applicant and/or resident with The Evergreens Foundation at any of their facilities and may only be terminated at an earlier date by myself, in writing.

Dated this _____ day of _____, 20____

Applicant/Patient Signature

Witness Signature

Applicant/Patient Printed Name

Witness Printed Name

Medical Questionnaire

Patient Information

Last Name		First Name		Date of Birth	
Street			City	Province	Postal Code

Examination Information

Attending Physician		Clinic Name		Date Examined	
Street			City	Province	Postal Code
Telephone		Fax			

Instructions

Oxygen required?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Intermittent	
If yes, is assistance required?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gastrointestinal:		<input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Colostomy Bag	
Urinary:		<input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Intermittent <input type="checkbox"/> Urinary Drainage Bag	
If applicable, please explain any assistance that may be needed with above:			
Any specific behavioural or social disturbances?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain:			



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Mental Health/Memory & Orientation:	
Any alcohol or substance abuse issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain:	
Any chronic diseases which may cause incapacitation to the point of special care in the future?	
Has your patient been hospitalized for a chronic condition in the past 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain:	
Any communicable diseases that would jeopardize the health of other vulnerable seniors living in the lodge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain:	
Please comment on any specific medical concerns our employees should be alert to:	

Any known Allergies that Housekeeping or Kitchen staff need to be aware of?	
The Lodge endeavours to accommodate low sodium and diabetic diets. Does your patient have any dietary restrictions? (Please list)	
Can the patient climb and descend stairs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can the patient walk without assistance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sight:	<input type="checkbox"/> Good <input type="checkbox"/> Impaired <input type="checkbox"/> Eyeglasses
Hearing:	<input type="checkbox"/> Good <input type="checkbox"/> Impaired <input type="checkbox"/> Hearing Aid(s) <input type="checkbox"/> Vertigo
Speech:	<input type="checkbox"/> Good <input type="checkbox"/> Impaired
Aids to daily living:	<input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Scooter <input type="checkbox"/> Other
Is the patient able to take their own medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If NO, will the patient require the MAP program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient able to dress themselves?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient able to bathe unassisted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your patient known to have wandering issues or significant confusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your patient able to manage personal hygiene?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your patient currently receiving home care support?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has a referral to home care been made?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would your patient be more appropriately accommodated in a site with 24-hour home care support?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Note: Basic Home Care support such as MAP and bathing are typically offered only for limited daily hours. Home Care service hours of operation may vary by community.



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The following section pertains to patients seeking admission to our Seniors Self-Contained Apartments

Is the patient capable of performing light housekeeping?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient capable of preparing their own meals?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you consider this applicant to be suitable mentally and physically to look after themselves in a self-contained apartment building where no special care, staff, nursing care, housekeeping or food service is available?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If NO, please explain:	

The following section pertains to patients seeking admission to one of our Lodges

In view of the foregoing, do you consider this applicant to be suitable mentally and physically to enter a Lodge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional comments:	

How long has the applicant been your patient?	
Will you be the attending physician when the applicant moves to the facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Physician's Signature

Date

Please Note the Following

Components of an HIA Consent

Section 34(2) of the HIA says that consent must be given in writing or electronically and include:

- What information is to be disclosed
- The purpose for disclosure of that information
- To whom the information can be disclosed
- That the person giving consent knows why it is being given, and accepts the risks
- The date the consent starts and the date the consent ends, if any
- That the person is aware that the consent can be revoked at any time

Duty to collect, use or disclose health information in a limited manner

58(1) When collecting, using or disclosing health information, a custodian must, in addition to complying with section 57, collect, use or disclose only the amount of health information that is essential to enable the custodian or the recipient of the information, as the case may be, to carry out the intended purpose.

58(2) In deciding how much health information to disclose, a custodian must consider as an important factor any expressed wishes of the individual who is the subject of the information relating to disclosure of the information, together with any other factors the custodian considers relevant.

(1999 cH-4.8 s5)