ESG Housing Society

Medical Form for Seniors Independent Housing

- AUTHORIZATION -

This medical information form is required by ESG Housing Society for all applicants seeking admission into our seniors independent living buildings. All information must be current within a six-month time frame. This form determines if the applicant is physically and cognitively able to look after themselves in a self-contained, independent living apartment complex.

Any charge for the completion of this form is the responsibility of the applicant.

I hereby authorize the medical professional that has records or knowledge of my health to provide full information to ESG or any authority acting on their behalf.

Applicant: _____ _____

Printed Name | Signature

FUNCTIONAL ASSESSMENT (Please print)

Patient's last name:	First name:	Middle name:
Current address:		
Date of birth (yyyy/mm/dd):	Phone:	

HEALTH CARE PROVIDER INFORMATION (Please print)

Your last name:	First name:
Clinic:	Phone:

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Address:		
How long has the applicant been under your care? _____		
Does your patient have any respiratory concerns? If **YES**, please explain: _____	☐ YES	☐ NO
Does this applicant smoke?	☐ YES	☐ NO
Does your patient have any gastrointestinal concerns? If **YES**, please explain: _____	☐ YES	☐ NO
Does your patient have any history of addictions that impacts their health? If **YES**, please explain: _____	☐ YES	☐ NO
Does your patient have any chronic diseases which may demand specialized care? If **YES**, please explain: _____	☐ YES	☐ NO

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Has your patient been hospitalized for a chronic condition in the past six months? If **YES**, please explain: _____	☐ YES	☐ NO
Does your patient have any communicable diseases that would jeopardize the health of other vulnerable seniors living in the building? If **YES**, please explain: _____	☐ YES	☐ NO

How is the patient's sight?	☐ Good	☐ Impaired	☐ Manages with vision aids
How is the patient's hearing?	☐ Good	☐ Impaired	☐ Manages with hearing aids
How is the patient's speech?	☐ Good	☐ Impaired	☐ Manages with supplementary aids

Does the patient require any aids for daily living? If **YES**, please choose the most suitable: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Scooter ☐ Other_____	☐ YES	☐ NO
Is the patient able to safely and accurately administer their own medication?	☐ YES	☐ NO
Is the patient able to dress themselves?	☐ YES	☐ NO
Is the patient known to have issues with falling? If **YES**, please explain: _____	☐ YES	☐ NO

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Is the patient known to have wandering issues or confusion? If **YES**, please explain: _____	☐ YES	☐ NO
Does the patient show any signs of memory loss? **If YES, please provide copy of MMSE or MOCA** and please explain: _____	☐ YES	☐ NO
Has the patient been diagnosed with any mental health condition that may impair their ability to manage independently? If **YES**, please explain: _____	☐ YES	☐ NO
Is the patient currently receiving Home Care Support? If **YES**, please explain: _____	☐ YES	☐ NO