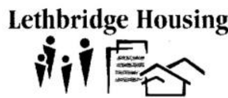
314 – 3 Street South
Lethbridge, Alberta T1J 1Y9



Telephone (403) 329-0556
Fax (403) 327-3906

MEDICAL INFORMATION for SOCIAL HOUSING

TO: ATTENDING PHYSICIAN *OR* NURSE PRACTITIONER

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.

AUTHORIZATION FOR RELEASE OF INFORMATION FROM THE MEDICAL REPORT:

I ______________________________ (applicant) 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 for independent seniors or adults. The term independent means that the applicant must be mentally and physically able to maintain themselves, 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. Perform daily living skills without cuing or reminders? ☐Yes ☐No ☐Unknown
4. Socially fit in with other seniors? ☐Yes ☐No ☐Unknown
5. Administer their own medication? ☐Yes ☐No ☐Unknown
6. Safely prepare meals using a stove and/or oven? ☐Yes ☐No ☐Unknown
7. Maintain the cleanliness of their own apartment? ☐Yes ☐No ☐Unknown

Could the applicant exit a multi-story building independently in the event of an emergency? ☐Yes ☐No

Has the applicant had a serious illness or injury in the past year? ☐Yes ☐No ☐Unknown
If yes, please explain: ____

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 ***(Please attach additional information if required)***
Mental Illness			
Cognitive Impairment			If yes, ☐Mild ☐Medium ☐Severe
Alzheimer's Disease			If yes, ☐Mild ☐Medium ☐Severe
Uncontrolled Aggressive or Violent behavior			
Infectious Diseases			If yes, type:
Alcohol or Drug Abuse			If yes, ☐ Past ☐ Present Details:

Does the Applicant use any mobility aids? If so, which of the following:

Cane ☐ Walker ☐ Manual Wheelchair ☐ Motorized Wheelchair ☐ Scooter ☐ Other: ____________

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

____

____

____

____

Name and Address of Physician OR Nurse Practitioner completing medical information:

Name: ______________________________ Clinic Address:_________________________

Clinic Phone No: ______________________ ____

Clinic Fax No: ________________________ ____

Signature: ____________________________ Date: ______________________________________

THIS MEDICAL REPORT IS VALID FOR 6 MONTHS

Please mail, fax, or email this form to:

LETHBRIDGE HOUSING AUTHORITY
314 – 3 Street South
LETHBRIDGE, AB T1J 1Y9
FAX: 403-327-3906
info@lethbridgehousing.ca

The personal information in this form is being collected by Lethbridge Housing Authority under section 33(c) of the Freedom of Information and Protection of Privacy Act for the purpose of administering applications for subsidized housing or rental benefits. If you have questions regarding the collection of this information, please contact Lethbridge Housing Authority at (403) 329- 0556.