WESTVIEW LODGE

5427 – 52 AVENUE,
ROCKY MOUNTAIN HOUSE,
ALBERTA T4T 1S9
(403) 845-3588 FAX: (403) 845-2228
wvlodge@telusplanet.net
www.rockyseniors.com

All information submitted in this application is kept strictly confidential and will be retained only for the purpose of processing this application or as long as the applicant is a resident. We require a medical to assess your suitability for Westview Lodge. By providing contact information, it is implied that you have obtained permission from them to give us their personal contact information and permission for us to contact them as deemed necessary. You can contact us at 403-845-3588.

APPLICATION FOR OCCUPANCY

FULL NAME_____
Surname (PLEASE PRINT) First Name

PRESENT ADDRESS_____

POSTAL CODE: _____ TELEPHONE: _____ BIRTH DATE: _____
MM-DD-YYYY

LENGTH OF RESIDENCE IN CANADA: _____ IN ALBERTA _____

IN COUNTY _____ SPECIFY_____

NAME, ADDRESS, PHONE NUMBER AND RELATIONSHIP OF RESPONSIBLE RELATIVE OR FRIEND TO BE NOTIFIED IN CASE OF EMERGENCY.

NAME: _____RELATIONSHIP _____

ADDRESS_____TELEPHONE _____

NAME: _____RELATIONSHIP _____

ADDRESS_____TELEPHONE _____

EXECUTOR:

NAME: _____TELEPHONE _____

ADDRESS _____

****What is your total income from Line 150 of your Notice of Assessment (Income Tax)? $_____**

ALBERTA HEALTH CARE INSURANCE NUMBER_____

SOCIAL INSURANCE NUMBER_____

AN UP TO DATE MEDICAL CERTIFICATE IS REQUIRED BEFORE ADMISSION.

I hereby understand and agree that special care shall not be provided in Westview Lodge and that should I require special care in the future, I shall move to a facility providing same, upon request.
IMPORTANT NOTICE TO APPLICANTS: Once your applicant has been given approval in principle, and you accept the accommodation offered, you will be provided with a lodge resident's Terms of Occupancy, which together with this Application for Occupancy shall form the basis of your occupancy at Westview Lodge.

_____ _____
Signature of Applicant Witness

Date _____

PLEASE RETURN COMPLETED QUESTIONAIRE TO:
WESTVIEW LODGE
5427 52ND AVENUE
ROCKY MOUNTAIN HOUSE, AB
T4T 1S9

NAME: _____ TELPHONE: _____

DATE OF BIRTH: _____

ADDRESS: _____

_____

ALTERNATE CONTACT:

NAME: _____TELEPHONE: _____

ADDRESS: _____

_____

FAMILY DOCTOR:

NAME: _____TELEPHONE: _____

ADDRESS: _____

_____

1. DO YOU COOK YOUR OWN MEALS? ____YES ____NO
   - ❖ If no, what other arrangements have you made to provide for your nutritional needs? _____

     _____
   - ❖ How many meals do you eat each day? _____
   - ❖ Which ones? ____Breakfast ____Dinner _____Supper

- ❖ Who do you eat your meals with? _____
- ❖ Do you have well balanced and nutritious meals? ____Yes ____No
- ❖ What do you consider a well-balanced meal? _____

_____

- ❖ Do you have food allergies or require a special diet?

____Yes ____No

- ❖ Do you have difficulty swallowing or chewing? ____Yes ____No

2. How often do you visit with friends? _____
   - ❖ What activities do you enjoy? _____

   _____
   - ❖ What functions in the community do you attend? _____

   _____

3. Do you drive? ____Yes ____No
   - ❖ If not, what arrangements do you make for transportation? _____

   _____
   - ❖ Is your residence located in town or country? _____
   - ❖ How far are you from the nearest town? _____km
   - ❖ How far are you from the nearest hospital? _____km

4. Do you have a “Help” line installed? ____Yes ____No
   - ❖ Who responds in case of an emergency? _____
   - ❖ What equipment do you have in your home for your personal safety, i.e. bath rails, etc.? _____

   _____

5. Do you manage your personal care and hygiene? ____Yes ____No

- If not, what assistance do you receive and who assists you? _____

_____

_____

- Do you wear glasses? ____Yes ____No
- Are you able to read or watch television? ____Yes ____No
- Do you wear a hearing aid? ____Yes ____No

6. Has your health changed in the last six months? ____Yes ____No

- What were the changes and what has been done about them? _____

_____

- Have you been hospitalized or required medical attention in the last six months? ____Yes ____No
- How many times have you visited the doctor's office in the past year? _____
- Please list medical conditions you have been diagnosed with. _____

_____

- Do you require oxygen? ____Yes ____No
- Do you smoke? ____Yes ____No
- Do you have problems with bladder control? ____Yes ____No
- Do you have problems with bowel control? ____Yes ____No

7. Are you able to climb stairs? ____Yes ____No

- Do you use a cane, walker, and /or a wheelchair for mobility assistance? ____Yes ____No

8. List all services received through community support services, i.e. Home Care, West Country Family Services, etc. _____

_____

9. What other housing options are you considering? _____

_____

10. Does existing housing structure provide accessibility for your mobility needs?

____Yes ____No

- That is, if in a wheelchair, is the home wheelchair accessible?

____Yes ____No

11. Do you own or rent your present accommodation? ____Own ____Rent

- If renting, name of your present landlord: _____

Telephone: _____ Address: _____

- Is your present accommodation: ____House ____Apartment?
- Elevator ____Yes ____No
- Rooming House _____ Motel/ Hotel____ Other____
- Details:

_____

- Rooms in present accommodation: ____Kitchen ____Living Room

____Dining Room ____Bathroom # of Bedrooms____

- Number of person(s) sharing your present accommodation:

____Adults ____Children

12. Do you receive Alberta Senior Benefits? ____Yes ____No

13. How long have you lived in the Clearwater County? _____

- How long have you lived in Rocky Mountain House? _____
- How long have you lived in the Village of Caroline? _____
- How long have you lived in Alberta? _____

14. Do you have family in the area? ____Yes ____No

15. Please give reasons for wanting to move to Westview Lodge?

_____

_____

16. If a room were available, would you move in immediately?

____Yes ____No

Any comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

****

WHEN YOU BOOK THE APPOINTMENT PLEASE LET THEM KNOW THAT IT IS FOR A "MEDICAL".

This makes sure that enough time is booked for the appointment with your Doctor.

****

TO: ATTENDING PHYSICIAN

Do not return this medical certificate to the applicant. Please complete and return directly to:

ADMINISTRATOR- **WESTVIEW LODGE**
5427 – 52 Avenue, ROCKY MOUNTAIN HOUSE, AB T4T 1S9
Telephone: 403-845-3588 Fax: 403-845-2228

I, _____HEREBY CONSENT TO THE RELEASE OF THIS INFORMATION TO ROCKY SENIOR HOUSING COUNCIL AS PART OF MY APPLICATION TO WESTVIEW LODGE/SELF CONTAINED UNITS (SCU).

_____ _____
Signature of Applicant Date

****

Name of Applicant _____ Age _____

Date of Examination _____

NOTE TO EXAMINING PHYSICIAN:

If this is a Lodge applicant; they must be able to feed themselves in a common dining room, get to meals and toilet independently. **The need for home care and other services MUST be arranged prior to admission.** Westview Lodge does not provide any home care or medical services.

Is Applicant physically able to wait on himself/herself? If answer is no, please explain in detail?

Condition

Is there any past or present evidence of?

Depression	☐Yes	☐No
Cognitive Impairment	☐Yes	☐No
Alzheimer's Disease	☐Yes	☐No
Dementia	☐Yes	☐No
Mental Illness	☐Yes	☐No

If you answered yes to any of the above, please give detail of severity and if the applicant is being treated at this time: _____

Diabetes ☐Yes ☐No
Insulin ☐Yes ☐No

Communicable Disease ☐Yes ☐No Type: _____

Infectious Diseases/ Antibiotic Resistant Diseases: ☐Yes ☐No

Chronic Disease which would require special care: ☐Yes ☐No

Oxygen required ☐Yes ☐No If Yes, ☐Mild ☐Medium ☐Severe

Gastrointestinal ☐Yes ☐No If Yes, ☐Mild ☐Medium ☐Severe

Bladder ☐Continent ☐Incontinent ☐Intermittent

Bowel ☐Continent ☐Incontinent ☐Intermittent

Catheter ☐Yes ☐No

Colostomy ☐Yes ☐No

Physical Disability ☐Yes ☐No Describe_____

Requires assistance transferring in & out of bed and to washroom:
☐Yes ☐No

Extra Assistance

Is your patient on Home Care? ☐Yes ☐No

Does your patient require medication assistance? ☐Yes ☐No

Does your patient require a special diet? ☐Yes ☐No

Intellectual Level of Functioning

Cooperative	☐ Yes	☐ At Times	☐ No
Aggressive	☐ Yes	☐ At Times	☐ No
Tendency to Wander	☐ Yes	☐ At Times	☐ No
Confused	☐ Yes	☐ At Times	☐ No
Destructive	☐ Yes	☐ At Times	☐ No
Unpleasant	☐ Yes	☐ At Times	☐ No
Violent Behavior	☐ Yes	☐ At Times	☐ No
Habits	☐ Yes	☐ At Times	☐ No

Do you consider your patient to be suitable mentally and physically to enter Westview Lodge where no special care, nursing care, or special diets are available?

☐ Yes ☐ No

RATING OF ACCEPTABILITY: A) ____, B) ____, C) ____, D) ____

A) Totally
B) Defects present, but controlled medically or surgically
C) Doubtful, because of senile changes, unclean habits
D) Unacceptable, chronic invalid, etc.

SIGNATURE OF PHYSICIAN: _____

ADDRESS: _____

_____

TELEPHONE
INCLUDE AREA CODE: _____