



**CONFIDENTIAL MEDICAL REPORT**  
**LODGE UNITS ONLY**

This medical information form is required by the Smoky Lake Foundation for applicants seeking admission into Vilna Lodge or Bar-V-Nook Manor (Independent Living). All information must be current within one month. These units are rented only to Senior Citizens who can administer to their own personal needs.

Name of Applicant: \_\_\_\_\_

Current Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**I authorize my physician to release medical information to the Smoky Lake Foundation:**

\_\_\_\_\_  
**Date** **Applicant's Signature**

**PHYSICIAN TO COMPLETE** (PLEASE PRINT)

How long has the applicant been your patient? \_\_\_\_\_

**1. Physical Examination:**

**Sight:** Good \_\_\_\_\_ Impaired \_\_\_\_\_

**Hearing:** Good \_\_\_\_\_ Impaired \_\_\_\_\_

**Weight:** \_\_\_\_\_ **Height:** \_\_\_\_\_

**Mobility:** Walks **without** help \_\_\_\_ Walks **with** help \_\_\_\_ Uses walker \_\_\_\_ Uses Wheelchair \_\_\_\_

**Blood Pressure:** \_\_\_\_\_

**Diabetic? (Y/N)** \_\_\_\_\_ **If Yes, Medication** \_\_\_\_\_

**Any significant impairment:** \_\_\_\_\_

Does the applicant suffer from any communicable disease whereby their presence in the lodge would jeopardize the physical welfare of the other guests?

**Yes** \_\_\_\_ **No** \_\_\_\_ **Comments** \_\_\_\_\_

Is the applicant suffering from any chronic disease, which incapacitates them to the point where they require special care? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

If yes please give details \_\_\_\_\_

Does the applicant use oxygen? **Yes** \_\_\_\_ **No** \_\_\_\_ If yes, to what degree \_\_\_\_\_



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**2. Activities of Daily Life**

	<b>Full Assistance Needed</b>	<b>Partial Assistance Needed</b>	<b>Supervision Only</b>	<b>None Needed</b>
Washing face and hands	_____	_____	_____	_____
Grooming and shaving	_____	_____	_____	_____
Dressing	_____	_____	_____	_____
Bathing	_____	_____	_____	_____
Feeding	_____	_____	_____	_____
Toileting	_____	_____	_____	_____
	<b>Complete</b>	<b>Partial</b>	<b>Occasional</b>	<b>None</b>
Bladder Incontinence	_____	_____	_____	_____
Bowel Incontinence	_____	_____	_____	_____
Catheter:	<b>Yes</b> _____	<b>No</b> _____		
Colostomy:	<b>Yes</b> _____	<b>No</b> _____		

**3. Intellectual Level of Functioning:**

	<b>Yes</b>	<b>At times</b>	<b>No</b>
Cooperative	_____	_____	_____
Aggressive	_____	_____	_____
Tendencies to wander	_____	_____	_____
Confused	_____	_____	_____
Destructive Habits	_____	_____	_____
Does the applicant show any signs of Dementia? (Y/N) _____ If Yes, to what degree? _____			

Has the applicant ever been diagnosed with mental illness: **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

Is the applicant being treated at this time: **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

Are there communication limitations? **Yes:** \_\_\_\_\_ **No** \_\_\_\_\_

If yes, what is the reason?: \_\_\_\_\_

**4. Medical Diagnosis:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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**5. Medications:**

Does this Patient require assistance with medication? (MAP) **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

Allergies or Drug Intolerance: \_\_\_\_\_

Has there ever been substance abuse?: **Yes** \_\_\_\_ **No** \_\_\_\_ Please explain \_\_\_\_\_

If yes, what type of care is required? \_\_\_\_\_

**6. Diet:** Regular \_\_\_\_\_ Low salt \_\_\_\_\_ Diabetic \_\_\_\_\_ Other \_\_\_\_\_

Food Allergies: \_\_\_\_\_

Do you consider this individual to be suitable mentally and physically to enter a lodge without special nursing care? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

Should he/she be placed on Home Care where minimal medical and social care are provided?

**Yes** \_\_\_\_\_ **No** \_\_\_\_\_

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

**Heidi Kugler-Kane, Lodge Manager**  
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**OR**

**Betty Elson, Lodge Manager**  
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SMOKY LAKE, AB T0A 3C0  
Phone 780-656-4217 ext. 3  
Fax 780-656-4277  
Email: [bvnmanager@smokylakefoundation.ca](mailto:bvnmanager@smokylakefoundation.ca)

\_\_\_\_\_  
**Examining Physician (Please Print)**

\_\_\_\_\_  
**Physician's Signature**

Phone: \_\_\_\_\_