The following is an application for residency to:

Westbourne Place
877 – 64th Avenue NW
Calgary, Alberta T2K 5J4
Fax: 403-274-8384

To be filled out by a Physician for the Applicant

Note: Westbourne is a "Non-Smoking Independent Living Facility". It is a low-income apartment building for people 65 years and older that can live, cook and care for themselves independently. Our facility does not have wheelchair ramps; it is not accessible for any "type" of motorized wheelchair. We do not serve or provide meals to our residents. Our apartments have their own kitchen, bathroom and are completely self-contained. We are not to be confused with "a Nursing Home" a "Lodge" or an "Assisted Living Facility".

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a. Name of Applicant: _____
b. Alberta Health Card #_____
c. Blue Cross # _____
d. Date of Medical Examination: _____
e. How long has the applicant been your patient? _____

1. Is the applicant physically able to wait on him/her self? _____ If no please explain:
   _____
   _____
2. Does the applicant suffer from any condition that might jeopardize the welfare of others? _____ If yes, please explain: _____
   _____
   _____
3. Do you consider the applicant mentally and physically competent for "independent living" in an independent living apartment? _____ If no please explain: _____
   _____
   _____
4. Has the applicant had a serious illness or injury within the past year? _____ If yes please explain: _____
   _____
5. Does this applicant require Home care services? Yes ____ No _____ If "Yes" what services need to be rendered? _____
   _____
   _____
   Any other support agencies involved/needed? Yes ____ No _____ Please list: __
   _____
   _____
6. Please list all prescribed medications: _____
   _____
   _____
   _____
7. Is this applicant able to administer his/her own medication? Yes ____ No _____
8. Is this applicant able to negotiate stairs? Yes ____ No _____
9. Do you have any concerns regarding anger, dementia, Alzheimer or alcoholism for this applicant? Yes ____ No _____
   If yes, please explain: _____
   _____
   _____

Does the applicant suffer from or have any history of any of the following disorders:			
Mental:	**Yes**	**No**	**If "Yes" Please Explain:**
1. Memory Loss			
2. Wandering			
3. Confusion			
4. Aggressive			
5. Violence			
6. Depression			
Physical:	**Yes**	**No**	
7. Cardiovascular			
8. Respiratory			
9. Epilepsy			
10. Diabetes			
11. Allergies			
12. Visual			
13. Hearing			
14. Incontinence			
Addictions:	**Yes**	**No**	
15. Smoking			
16. Alcoholism			
17. Substance Abuse			
Does this Applicant have:	**Yes**	**No**	
18. Pacemaker			
19. Oxygen			
20. Urinary Bag			
21. Colostomy Bag			
22. Artificial Limb			
23. Walking Aide			
24. Other daily used Aides?			

_____ _____

Doctor's Signature Please Print Doctor's Name

_____

Date

Please Provide Doctor's Contact Information	
Office Phone Number:	
Hospital Phone Number:	
Hospital Affiliation:	
Address of Office:	

Please Note: By Signing this form I give the right for Westbourne Place to collect and hold in confidence the information above.

_____ _____

Applicant's Signature Please Print Applicant's Name

_____

Date

--APPLICANT, PLEASE RETURN COMPLETED FORM TO WESTBOURNE PLACE--