



The Gorge View Society

Affiliated with VICTORIA PRESBYTERY of the UNITED CHURCH OF CANADA

#11 Chown Place Victoria, BC V9A 1H5 Website: gorgeviewsociety.bc.ca
Ph: 250-360-1977 Fax: 250-360-1976 e-Mail: gorgeview@shaw.ca

NAME: _____

CONTACT #: _____

SIN #: _____

CONFIDENTIAL MEDICAL REPORT

NAME: _____ DATE: _____

I, (signature) _____, an applicant for residency, hereby authorize my Physician, Dr. _____ Phone: (250) _____

to provide medical information to the Society Administrator. I understand the NO medial care, attention or diets are provided by the Gorge View Society.

The above named prospective tenant is being considered for a suite at Gorge View Homes, an independent living community for low-income seniors. It is imperative that they be able to look after themselves and not require assistance or supervision. Housing only is provided.

Applicant is a known patient in my practice: Yes / No

Applicant is a drop-in to a clinic: Yes / No

1. VISUAL ACUITY: Can applicant function alone? Yes No

2. HEARING: Normal Not Normal If not normal, give details: _____

3. URINARY FUNCTION: Normal Not Normal If not normal, give details: _____

4. CARDIO-PULMONORY FUNCTION: Normal Not Normal If not normal, give details: _____

5. DIGESTIVE TRACT: Normal Not Normal If not normal, give details/ is special diet required?: _____

6. MUSCULATURE: Normal Not Normal If not normal, give details: _____

7. DERMATOLOGY: Normal Not Normal If not normal, give details: _____

8. MENTAL: Normal Not Normal If not normal, give details: _____

9. ALLERGIES: Normal Not Normal If not normal, give details: _____

10. DOES APPLICANT SMOKE OR USE TOBACCO PRODUCTS? Yes No
11. DOES APPLICANT USE ALCOHOL BEVERAGES TO EXCESS? Yes No
12. Can Applicant function unaided? Yes No If not, please detail: _____

ADDITIONAL COMMENTS: _____

DOCTOR'S SIGNATURE & STAMP: _____ DATE: _____