FUNCTIONAL ASSESSMENT

This form MUST BE COMPLETED by a health care provider – a physician, registered nurse practitioner or naturopath ND.

Dear Health Care Provider:

As part of the application process for Silvera for Seniors, a prospective resident is required to provide a current assessment of their ability to independently manage their daily living. The Functional Assessment may also be required in a case where it is believed a resident's needs may have changed over time.

The information requested in this form is to ensure that Silvera's supports and services align with the applicant's/resident's needs.

Please complete the questionnaire in full. Please be aware **that Silvera communities are non-medical and are not alcohol restricted (except Beaverdam Memory Care)**. Residents may access health supports through Alberta Health Services Home Care and/or through arrangements they have with private health providers.

Thank you in advance for completing this questionnaire in its entirety, including signing the document.

If you have any questions regarding the information contained in this section of our application, please feel free to contact Silvera's Sales & Leasing team at 403.567.5301.

PLEASE COMPLETE THIS PAGE

Consent to the Disclosure of Individual Identifying Health Information (Health Authority)

I,_____, authorize the attached Functional
Applicant Name
Assessment individually identifying myself to be disclosed by_____,
Physician's Name
in accordance with section 34 of the Health Information Act, to Silvera for Seniors, for the following purpose(s): Application & Admission Process or Eligibility Reassessment: I understand that this information will be kept confidential and will be used only in my best interests for assessing my health and social needs, for planning services to meet those needs, and for determining appropriate housing for me. I understand that under section 58 of the Health Information Act (HIA), my express wishes must be considered and I have the right to indicate any portion of my health information that I wish to be kept confidential by my Physician/Nurse Practitioner and not disclosed to others.

I understand the risks and/or benefits that are associated with disclosing or not disclosing my information. I release Silvera for Seniors, its employees and agents, from all claims which may arise as a result of the release of the information. This authorization shall be valid during the time in which I am an applicant and/or resident with Silvera for Seniors at any of their facilities and may only be terminated at an earlier date by myself in writing.

I am aware that I have the right to revoke a release of information to the above noted persons or organizations at any time in writing to Silvera for Seniors.

SIGN HERE X _____

Signature of Applicant Date

_____

Signature of Witness Print Witness' Full Name

CANCEL	**Please complete this section only if you would like to cancel your consent.** I,_____, cancel this permission. I understand that some action may have been taken prior to cancellation. Applicant Signature: _____ Witness:_____ Date signed:_____/_____/_____ M D Y

Applicant/Resident Information (Please Print and Complete)	
Last Name:	First Name:
Date of birth:	Phone #:
Current Address:	

Health Care Provider Information (Please Print and Complete)	
Last Name:	First Name:
Clinic:	Phone #:
Address:	License #:

How long has the applicant been under your care? _____

Does your patient have any respiratory concerns? Yes ☐ No ☐

If yes, please explain

_____

_____

_____

Does your patient have any gastrointestinal concerns? Yes ☐ No ☐

If yes, please explain

_____

_____

_____

Does your patient have any urinary and/or bowel concerns? Yes ☐ No ☐

If yes, please explain

_____

_____

_____

Does your patient have any history of addictions that impact their health?

Yes ☐ No ☐

If yes, please explain how the patient is managing their addiction.

_____

_____

_____

Any chronic diseases which may cause incapacitation to the point of specialized care in the near future? Yes ☐ No ☐

If yes, please explain

_____

_____

_____

Has your patient been hospitalized for a chronic condition in the past six months?

Yes ☐ No ☐

If yes, please explain

_____

_____

_____

Does your patient have any communicable diseases that would jeopardize the health of other vulnerable seniors living in the building? Yes ☐ No ☐

If yes, please explain

_____

_____

_____

Known allergies that our housekeeping or dining services need to be made aware of? Does your patient have any dietary restrictions? (Please list)

_____

_____

_____

How is the patient's sight? Good ☐ Impaired ☐ Managed with vision aids ☐

How is the patient's hearing? Good ☐ Impaired ☐ Managed with hearing aids ☐

How is the patient's speech? Good ☐ Impaired ☐ Managed with supplementary aids ☐

Does the patient require any Aids to Daily Living? Yes ☐ No ☐

If yes, please choose the most suitable: Cane ☐ Walker ☐ Wheelchair ☐ Scooter ☐ Other ☐

Is the patient able to safely and accurately administer his/her own medication? Yes ☐ No ☐

Is the patient able to dress themselves? Yes ☐ No ☐

Is the patient able to bathe/shower unassisted? Yes ☐ No ☐

Is the patient known to have a history of falls? Yes ☐ No ☐

If yes, please explain

_____

_____

_____

Is the patient known to have occurrences of wandering or significant confusion? Yes ☐ No ☐

If yes, please explain

_____

_____

_____

Does the patient show any signs of memory loss? Yes ☐ No ☐

If yes, please explain and ATTACH a copy of MMSE, MOCA, or SLUMS that was completed (within the last 60 days)

_____

_____

_____

Has the patient been diagnosed with any mental health condition that may impair their ability to manage independently at present or in the near future? Yes ☐ No ☐

If yes, please explain

_____

_____

_____

Has the patient been diagnosed with any physical condition that may impair their ability to manage independently at present or in the near future? Yes ☐ No ☐

If yes, please explain

_____

_____

_____

Is the patient currently receiving Home Care Support? Yes ☐ No ☐ Not applicable ☐

If yes, please explain

_____

_____

_____

Housing Options at Silvera for Seniors

Silvera offers a variety of housing options. **All housing options are non-medical; that is, Silvera does not employ health care workers. Residents may have scheduled home care support through AHS or a private provider. (Max. 20 hours scheduled care/week)**

Independent Living – Accommodation Only (self-contained seniors' apartment)

Residents must be able to manage their daily needs and activities, including shopping, meal preparation, cleaning. There are no employees on site, although residents may have home care arrangements or other supports activated. Residents can access maintenance on call 24-hours/day and can access a Community Manager or Resident Support Coordinator on business days. Is this patient capable of functioning independently in this setting?

Yes ☐ No ☐

If no, please explain

_____

_____

_____

Supportive Living - Housing with Full Services (private suite in a congregate site)

Residents must be able to manage their daily needs and activities, within a congregate setting. Services provided include dining, weekly housekeeping, maintenance, life, learning and leisure programs, and 24-hour employees on-site.

Is this patient capable of functioning independently in this setting? Yes ☐ No ☐

If no, please explain

_____

_____

_____

Would the patient be more appropriately accommodated in a site with a higher level of care than Silvera, that offers 24-hour health/medical support? Yes ☐ No ☐

If yes, please explain

_____

_____

_____

This assessment is valid for six (6) months only. The applicant/resident is responsible for notifying Silvera for Seniors if their health circumstances change, affecting the validity of this application.

_____ _____

Health Care Provider Signature
*Physician, Registered Nurse Practitioner or Naturopath ND

Date