FRIENDS OF ST-JOSEPH'S MANOR
APPLICATION FOR RESIDENCY

Name: _____

Present address: _____ Phone # _____

DOB: _____

Single ☐ married ☐ widowed ☐ divorced ☐ separated ☐ Spouse _____

Father's Name _____ Mother's Maiden Name _____

Health # _____ Expiry Date _____

Reason for moving from present address _____

Desired date of accommodation _____ Size of room preferred: _____

Contact Person (in case of emergency) _____ Relationship _____

Address: _____ Phone _____

Person with power of attorney _____ Relationship _____

Address: _____ Phone _____

Doctor: _____ Phone _____

HEALTH STATUS

Eyesight: Good ☐ Fair ☐ Glasses ☐ Artificial eye ☐ Contact lenses ☐

Hearing: Good ☐ Fair ☐ Hard of hearing ☐ left ear ☐ right ear ☐

Hearing aid: left ear ☐ right ear ☐

Dentures: upper ☐ lower ☐ Partial ☐

Mobility: Self ☐ Cane ☐ Walker ☐ Wheelchair ☐ Requires assistance to _____

Diet: _____ Food dislike _____

Allergies _____

Hospitalized in the past year yes ☐ no ☐ **If yes when?** _____

Give reasons and length of stay: _____

DISEASES AND CHRONIC DISABILITIES: (please check)

Diabetes: ☐ controlled by: diet ☐ oral medication ☐ insulin ☐

Need assistance with injection: yes ☐ no ☐ Hypertension ☐ Heart disease ☐

Arteriosclerosis ☐ Emphysema ☐ Asthma ☐ Chronic bronchitis ☐ Arthritis ☐

Other medical problems: _____

_____

Clubs, hobbies, interests: _____

Documents required upon admission

- **Please note that a level of care decision (DNR) signed by your physician.**
- **A long form birth certificate.**
- **Medications presently taken (A list from the Pharmacy will be required).**

Signature _____ Date _____

(Please return this completed application to Box 609, 24 Reid Street Campbell's Bay QC, for information Phone 819-648-5905)