



**Abbeyfield Houses Society of Caledon**  
22 Walker Road East, Caledon East, ON L7C 3K2  
Tel: 905-860-0181  
Email: [intake@abbeyfieldcaledon.org](mailto:intake@abbeyfieldcaledon.org)

*Housing for Independent Seniors*

**Abbeyfield Caledon**  
Medical Certification for Residency

**Overview**

The purpose of this Medical Certification form is to verify through the applicant’s personal physician, that Abbeyfield Caledon House would be an appropriate accommodation option, consistent with the applicant’s physical and mental health.

Abbeyfield Caledon is a home that provides ***fit, independent and self-sufficient*** seniors with affordable, companionable and safe housing in a family style household. The Abbeyfield House provides accommodation for senior citizens who are capable of ***maintaining themselves and their private suites***. Abbeyfield provides provide (2) congregate meals – lunch and dinner with a self-serve breakfast. Day to day operations are run by a House Manager, however, Abbeyfield ***does not provide*** personal or nursing support.

The following answers are required to inform Abbeyfield Caledon in confidence (through the Medical Advisor) as to the overall health/medical condition and well-being of a potential resident candidate.

**To be completed by the physician:**

**Applicant’s full name**

\_\_\_\_\_

Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Health Card No. \_\_\_\_\_

Version Code \_\_\_\_\_

**Current Medical Conditions:** (Please list physical and mental conditions currently observed or under treatment, including evidence of a communicable disease)

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**Current Medications:**

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**May administer own medication?** Yes  No

**Requires oxygen?**  Amount \_\_\_\_\_ Mode \_\_\_\_\_

**Allergies**

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**Diet restrictions (Please list any food allergies or intolerances)**

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**VISION** (with glasses, if worn) Adequate  Impaired  Blind  Glasses

**HEARING** (with aid if worn) Adequate  Impaired  Deaf  Aids

**MOBILITY:** Excellent  Good  Fair  Poor

**Requires use of a walker or walking aid?** Yes  No

**Is the applicant approved for driving?** Yes  No  Don't Know

## **Mental Health:**

**Does the applicant display normal cognitive abilities?** Yes  No  Sometimes

**Is there onset signs dementia or Alzheimer's?** Yes  No

Please provide an overall assessment of the applicant's mental and physical health

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In your opinion, is the applicant able to live independently and provide self-care and manage day to day living tasks in a congregate setting? (ie. Personal hygiene, eating, laundry, errands, physical mobility, emotional intelligence, appropriate social interactions etc.) Please Comment:

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Are there any factors or conditions, which do, or are likely to, in the short term, cause this person to be unable to personally provide adequate *self-care* in the environment being considered? Please provide and explanation below:

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**Physician's Name:** \_\_\_\_\_

**Physician's Address**

\_\_\_\_\_

**Tel:** \_\_\_\_\_ **Email:** \_\_\_\_\_

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

**Date:** \_\_\_\_\_