

Application No: \_\_\_\_\_

**Pre-screening Guide – Work sheet** *Independent Living*

Total Long-term Care

Name: \_\_\_\_\_ Province: \_\_\_\_\_ DOB: \_\_\_\_\_ Spousal Discount: (Y/N): \_\_\_\_\_

HEIGHT & WEIGHT		Yes	No
Height: _____ Weight: _____		<b>CONTINUE</b>	<b>STOP</b> Inform applicant the acceptable limits.
Has this weight been stable for at least 12 months?		<b>CONTINUE</b>	<b>STOP</b> Inform applicant the acceptable limits.
UNDERWRITING PROCESS		Yes	No
<b>Medications</b>	<input type="checkbox"/> Specify: _____		<input type="checkbox"/>
Any change in medication?	<input type="checkbox"/> Specify: _____		<input type="checkbox"/>
<b>65 years+</b> Has seen a physician within the last 3 years?	<input type="checkbox"/> Specify: _____		<input type="checkbox"/>
Diagnosed with any conditions identified by a <b>yellow light?</b>	<input type="checkbox"/> Specify: _____ _____ _____		<input type="checkbox"/>
QUESTIONNAIRE			
Any medical exams, procedures or surgery planned?	<input type="checkbox"/> Specify: _____		<input type="checkbox"/>
Advised to consult a specialist?	<input type="checkbox"/> Specify: _____		<input type="checkbox"/>
CURRENT DISORDERS			
If diagnosed, specify: (see guide page 8)	Arthritis, Osteo or Rheumatoid _____		
	Osteoporosis _____		
	Asthma/Emphysema/COPD _____		
	Cancer or blood disorders _____		
	Heart Disease, Irregular Heart Beat, Valve Disease _____		
	Diabetes _____		
	Peripheral Vascular Disease? (poor circulation in the extremities) _____		
HEALTH SIGNS		Yes	No
Needs assistance to perform activities of daily living?	<input type="checkbox"/> Specify: _____		<input type="checkbox"/>
Uses assistive devices?	<input type="checkbox"/> Specify: _____		<input type="checkbox"/>
Diagnosed with any of the medical conditions identified by a <b>red light?</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Diabetes Insulin-Dependent</li> <li><input type="checkbox"/> Circulatory Disease (other than well-controlled hypertension)</li> <li><input type="checkbox"/> Neuropathy</li> <li><input type="checkbox"/> Renal Failure</li> <li><input type="checkbox"/> Retinopathy</li> <li><input type="checkbox"/> Skin or Leg Ulcers</li> <li><input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS) or HIV Positive</li> <li><input type="checkbox"/> Alzheimer's Disease</li> <li><input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease)</li> <li><input type="checkbox"/> Cirrhosis of the Liver</li> <li><input type="checkbox"/> Amputation due to disease</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Chronic Memory Loss, Senility, Dementia or Organic Brain Syndrome</li> <li><input type="checkbox"/> Multiple Sclerosis</li> <li><input type="checkbox"/> Cancer of two or more sites (excluding skin) or Metastatic Cancer (Cancer that has spread from the original organ)</li> <li><input type="checkbox"/> Muscular Dystrophy</li> <li><input type="checkbox"/> More than one mini-stroke (TIA), Stroke or Cerebrovascular Accident (CVA)</li> <li><input type="checkbox"/> Parkinson's Disease</li> <li><input type="checkbox"/> Neurogenic Bladder</li> <li><input type="checkbox"/> Renal Failure</li> <li><input type="checkbox"/> Huntington's Disease</li> <li><input type="checkbox"/> Paraplegia</li> <li><input type="checkbox"/> Quadriplegia</li> </ul>	

