



Charitable Number:  
11915-2064 RR 001

SLOVENIAN LINDEN FOUNDATION

52 Neilson Drive,  
Etobicoke, Ontario  
M9C 1V7  
Telephone: (416) 621-3820

e-mail: info@domlipa.ca  
website: www.domlipa.ca

Fax: 416-621-9876

## Application for Admission

Date of Application: Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

### PLEASE PRINT ALL INFORMATION

Name of Applicant \_\_\_\_\_ Date of Birth: Day \_\_\_\_\_ / Month \_\_\_\_\_ / Year \_\_\_\_\_

Present Address \_\_\_\_\_ Apt No \_\_\_\_\_

City or Town \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone No. where applicant can be reached ( \_\_\_\_\_ ) \_\_\_\_\_

Health Care Card No. \_\_\_\_\_ Version Code \_\_\_\_\_

Other Health Insurance \_\_\_\_\_ Policy No. \_\_\_\_\_

### IN THE EVENT OF AN EMERGENCY CONTACT:

1. Name \_\_\_\_\_

Address \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone No.: Home: ( \_\_\_\_\_ ) \_\_\_\_\_

Email: \_\_\_\_\_

2. Name \_\_\_\_\_

Address \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone No.: Home: ( \_\_\_\_\_ ) \_\_\_\_\_

Email: \_\_\_\_\_

TYPE OF ACCOMODATION REQUESTED:  Bachelor Suite  1 Bedroom Suite

### PLEASE INDICATE TO WHOM CHARGES FOR SERVICE ARE TO BE RENDERED

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone: Home: ( \_\_\_\_\_ ) \_\_\_\_\_ Business ( \_\_\_\_\_ ) \_\_\_\_\_

### FOR OFFICE USE ONLY:

Admission Date \_\_\_\_\_ Admission No. \_\_\_\_\_ Room \_\_\_\_\_ Bed \_\_\_\_\_

Name of Personal Physician of Applicant \_\_\_\_\_

Address \_\_\_\_\_ City or Town \_\_\_\_\_

Telephone No. (\_\_\_\_\_) \_\_\_\_\_

Do you plan to continue with your personal physician:  Yes  No

Do you have a Power of Attorney for Personal Care  Yes  No

If Yes, name of person holding Power of Attorney \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_

Telephone: Residence: (\_\_\_\_\_) \_\_\_\_\_ Business (\_\_\_\_\_) \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Recent weight change  Yes  No

Describe weight change \_\_\_\_\_

Do you use any of the following:

Glasses:  Yes  No  Reading only  All the time

Contact Lens:  Yes  No Type \_\_\_\_\_

Dentures:  Yes  No  Partial Upper  Partial Lower  Full Upper  Full Lower

Hearing Aid:  Yes  No  Left Ear  Right Ear  Both

Ambulatory Aid:  Cane  Walker  Wheelchair  Motor Scooter

Prosthesis:  Yes  No Describe \_\_\_\_\_

Brace:  Yes  No Describe \_\_\_\_\_

Splint:  Yes  No Describe \_\_\_\_\_

Pacemaker:  Yes  No Describe \_\_\_\_\_

Incontinence Products:  Yes  No Describe \_\_\_\_\_

Do you smoke?  Yes  No Amount smoked per day \_\_\_\_\_

Do you drink alcohol?  Yes  No Amount consumed per week \_\_\_\_\_

Native Language \_\_\_\_\_ Spoken language (s) \_\_\_\_\_

List hobbies, interests and social activities: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Religious affiliation: \_\_\_\_\_

Do you require a special diet?  Yes  No If Yes, please specify \_\_\_\_\_

Have you received a Pneumonia Vaccine?  Yes  No Date: \_\_\_\_\_

Have you received a Flu Vaccine?  Yes  No Date: \_\_\_\_\_

Do you have any allergies?  Yes  No Please list all allergies: \_\_\_\_\_  
\_\_\_\_\_

#### DO YOU REQUIRE ASSISTANCE WITH ANY OF THE FOLLOWING:

1. Putting on your clothes?  Yes  No If Yes, please describe: \_\_\_\_\_

2. Bathing?  Yes  No If Yes, please describe: \_\_\_\_\_

3. Personal grooming?  Yes  No If Yes, please describe: \_\_\_\_\_

4. Transferring from bed to chair?  Yes  No If Yes, please describe: \_\_\_\_\_

5. Toileting?  Yes  No If Yes, please describe: \_\_\_\_\_

#### NOTE: YOU MAY BE ASKED TO UPDATE THIS INFORMATION ANNUALLY

Government Old Age Pension  Yes  No Monthly \_\_\_\_\_ Annually \_\_\_\_\_  
*(Use present income)*

Canada Pension  Yes  No Monthly \_\_\_\_\_ Annually \_\_\_\_\_

Other Pension  Yes  No Monthly \_\_\_\_\_ Annually \_\_\_\_\_

Other Income  Yes  No Monthly \_\_\_\_\_ Annually \_\_\_\_\_

**Totals**  Yes  No Monthly \_\_\_\_\_ Annually \_\_\_\_\_

*Total Gross Income appearing on your last income tax return*

Please list all medications you are currently taking:

NAME	DOSAGE	FREQUENCY	REASON FOR TAKING

Please list all surgeries and/or medical problems you have had:

SURGERY OR MEDICAL PROBLEM	DATE	WHERE WAS TREATMENT GIVEN?

Form completed by: \_\_\_\_\_  
Name \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

Date \_\_\_\_\_

Fax: 416-621-9876

Charitable Number:  
11915-2064 RR 001

DOM LIPA  
SLOVENIAN LINDEN FOUNDATION



52 Neilson Drive,  
Etobicoke, Ontario  
M9C 1V7

Telephone: (416) 621-3820

e-mail: info@domlipa.ca  
website: www.domlipa.ca

## Pre-Admission Medical Assessment

To be signed by physician

Applicant's Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Current Residence \_\_\_\_\_ Health Card No. \_\_\_\_\_

Physician's Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ Fax \_\_\_\_\_

Postal Code \_\_\_\_\_

How long have you known the applicant? (Years) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Pulse: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_

### PRIMARY DIAGNOSIS

### STATUS

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### SECONDARY DIAGNOSIS

### STATUS

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### PRESENT MEDICATION

### DOSE & FREQUENCY

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

### KNOWN DRUG ALLERGIES / SENSITIVITIES

IS THE PATIENT CAPABLE OF ADMINISTERING OWN MEDICATION? YES: \_\_\_\_\_ NO: \_\_\_\_\_

Comments \_\_\_\_\_

**ALL INFORMATION IN THIS FORM WILL BE KEPT CONFIDENTIAL**

*continued on reverse ...*

**DATE OF LAST PHYSICAL EXAMINATION**

Did this examination include:	<u>Yes</u>	<u>No</u>	<u>Significant Results</u>
ECG	_____	_____	_____
Routine Blood Work	_____	_____	_____
Urinalysis	_____	_____	_____
Pneumonia Vaccine	_____	_____	_____
Chest X-Ray	_____	_____	_____
Influenza Vaccine	_____	_____	_____
Other _____	_____	_____	_____
Is the applicant currently under investigation by a specialist:	_____	_____	_____
Name _____	_____		
Reason _____	_____		

**PLEASE INDICATE CURRENT PROBLEMS / REQUIREMENTS:**

	<u>Yes</u>	<u>No</u>	<u>Comments</u>
Vision Impairment	_____	_____	_____
Hearing Impairment	_____	_____	_____
Special Dietary Requirements	_____	_____	_____
Mobility / Gait / Balance	_____	_____	_____
Walker Required	_____	_____	_____
Wheelchair Required	_____	_____	_____
Prone to fall / fractures	_____	_____	_____
Seizures / Loss of Consciousness	_____	_____	_____
Confusion / Memory Loss	_____	_____	_____
Drug / Alcohol Abuse	_____	_____	_____
Aggression / Acting Out	_____	_____	_____
Bowel / Bladder Incontinence	_____	_____	_____
History of:			
Hep A, B, C	_____	_____	_____
AIDS / HIV	_____	_____	_____
Tuberculosis	_____	_____	_____

**OTHER SIGNIFICANT HISTORY**

_____
_____

**PHYSICIANS SIGNATURE:**

<b>CONSENT:</b>	I, _____ authorize my physician to release to Dom Lipa and I authorize Dom Lipa to release to my physician or the hospital to which I may be admitted, any medical information that would benefit my well-being.
-----------------	--

Signature of Applicant _____	Date _____
------------------------------	------------

\*Must be completed by a doctor or certified staff

## Instructions for administering the Mini-Mental State Examination (MMSE)

### ORIENTATION

1. Ask the patient for the current year, season, date, day and time. If the patient has omitted part of the answer, ask for this part specifically, e.g., "Can you also tell me what season it is?"  
*Score 1 point for each correct answer.*
2. Ask the patient what country, province, city/town, and hospital/clinic you are in, and which floor you are on. Again, if the patient has omitted part of the answer, ask for this part specifically, e.g., "Can you also tell me what province we are in?"  
*Score 1 point for each correct answer.*

### REGISTRATION

Ask the patient if you may test his/her memory. Say the name of the 3 unrelated objects, clearly and smoothly, taking about 1 second to pronounce each word. After you have said all 3, ask the patient to repeat them all. This first repetition determines the patient's score.  
*Score 1 point for each object remembered.*

Once the score has been recorded, repeat the process (to a maximum of 6 times) until the patient can repeat all 3 objects. Record how many trials it took for the patient to remember all 3 objects. If all 3 objects are not eventually learned, recall cannot be meaningfully tested.

### ATTENTION AND CALCULATION

Ask the patient to spell the word "world" backwards. *Score 1 point per letter in correct order (e.g., DLROW=5; DLRW=4; DLW=3; OW=2; LDRWO=1).*

**Alternately**, ask the patient to subtract 7 from 100, then subtract a further 7 from that result, and so on for 5 subtractions (93, 86, 79, 72, 65).  
*Score 1 point per correct subtraction.*

### RECALL

Ask the patient to recall the 3 objects learned in the "registration" section of the test.  
*Score 1 point for each object remembered.*

### LANGUAGE

**Naming:** Show the patient a wristwatch and ask him/her what it is. Repeat for a pencil.  
*Score 1 point for each object named.*

**Repetition:** Ask the patient to repeat the following sentence after you: "No ifs, ands or buts".  
*Score 1 point for correct performance.*

**3-stage command:** Give the patient a piece of plain blank paper. Tell the patient to take the paper in his/her right hand, fold it in half, and put it on the floor.  
*Score 1 point for each section of the command performed.*

**Reading:** On the back of the MMSE page, print the sentence "Close your eyes" in letters large enough for the patient to see clearly. Ask him/her to read it and do what it says.  
*Score 1 point only if the patient actually closes his/her eyes.*

**Writing:** On the back of the MMSE page, ask the patient to write a sentence for you. Do not dictate a sentence; it is to be written spontaneously by the patient. It must contain a subject and verb and be sensible. Correct grammar and punctuation are not necessary.  
*Score 1 point only for a correct sentence.*

**Copying:** On the back of the MMSE page, draw intersecting pentagons, each side about 1 inch long. Ask the patient to copy the diagram exactly as it is.  
*All 10 angles must be present and 2 angles must intersect for the patient to score 1 point.*  
Tremor and rotation are ignored.

# Mini-Mental State Examination (MMSE)

Patient name: \_\_\_\_\_

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

Maximum score	
	<b>ORIENTATION</b>
5	( ) What (year) (season) (date) (day) (month) is it? <i>(1 point for each correct answer.)</i>
5	( ) Where are we: (province) (country) (town or city) (hospital or clinic) (floor)? <i>(1 point for each correct answer.)</i>
	<b>REGISTRATION</b>
3	( ) Listen to the following: "apple," "table," "penny." Repeat all 3. <i>(1 point for each correct answer.)</i>
# Trials:	( ) (Repeat the objects until the patient learns all 3. Make a maximum of 6 trials. Record the number of trials.)
	<b>ATTENTION AND CALCULATION</b>
5	( ) Spell "world" backwards. <i>(1 point for each letter in correct order.)</i> Alternate: Subtract 7 from 100. Take the result and subtract 7 from that. Continue until I ask you to stop. <i>(Continue for 5 subtractions. 1 point for each correct subtraction.)</i>
	<b>RECALL</b>
3	( ) What were the 3 objects we repeated earlier? <i>(1 point for each correct answer.)</i> (Note: Recall cannot be tested if all 3 objects were not remembered during registration.)
	<b>LANGUAGE</b>
2	( ) What are these? (pencil) (watch).
1	( ) Repeat the following: "No ifs, ands, or buts."
3	( ) Take a piece of paper in your right hand, fold it in half and put it on the floor. <i>(1 point for each section of the command performed.)</i>
	<b>READ AND OBEY</b>
1	( ) Read the following ("Close your eyes.") and do as it says.
1	( ) Write a sentence.
1	( ) Copy the following design on the back of this page:
	No construction problem
<b>Total score</b> (max. score 30)	

Adapted from Folstein MF et al. "Mini-Mental State": A practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res* 1975;12:189-198, and Cockrell JR, Folstein MF. Mini-Mental State Examination (MMSE). *Psychopharm Bull* 1988;24(4):689-692.  
© 2007 Pfizer Canada Inc., Kirkland, Quebec H9J 2M5



## Mini-Mental State Examination (MMSE)

### READING:

Close your eyes.

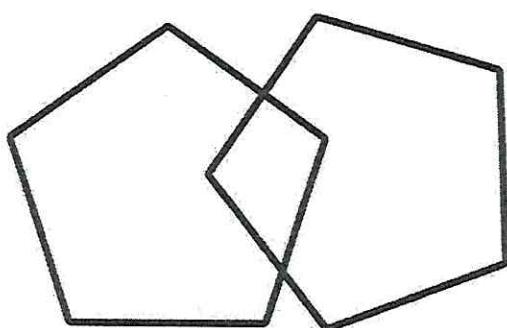
### WRITING:

---

---

---

### COPYING:

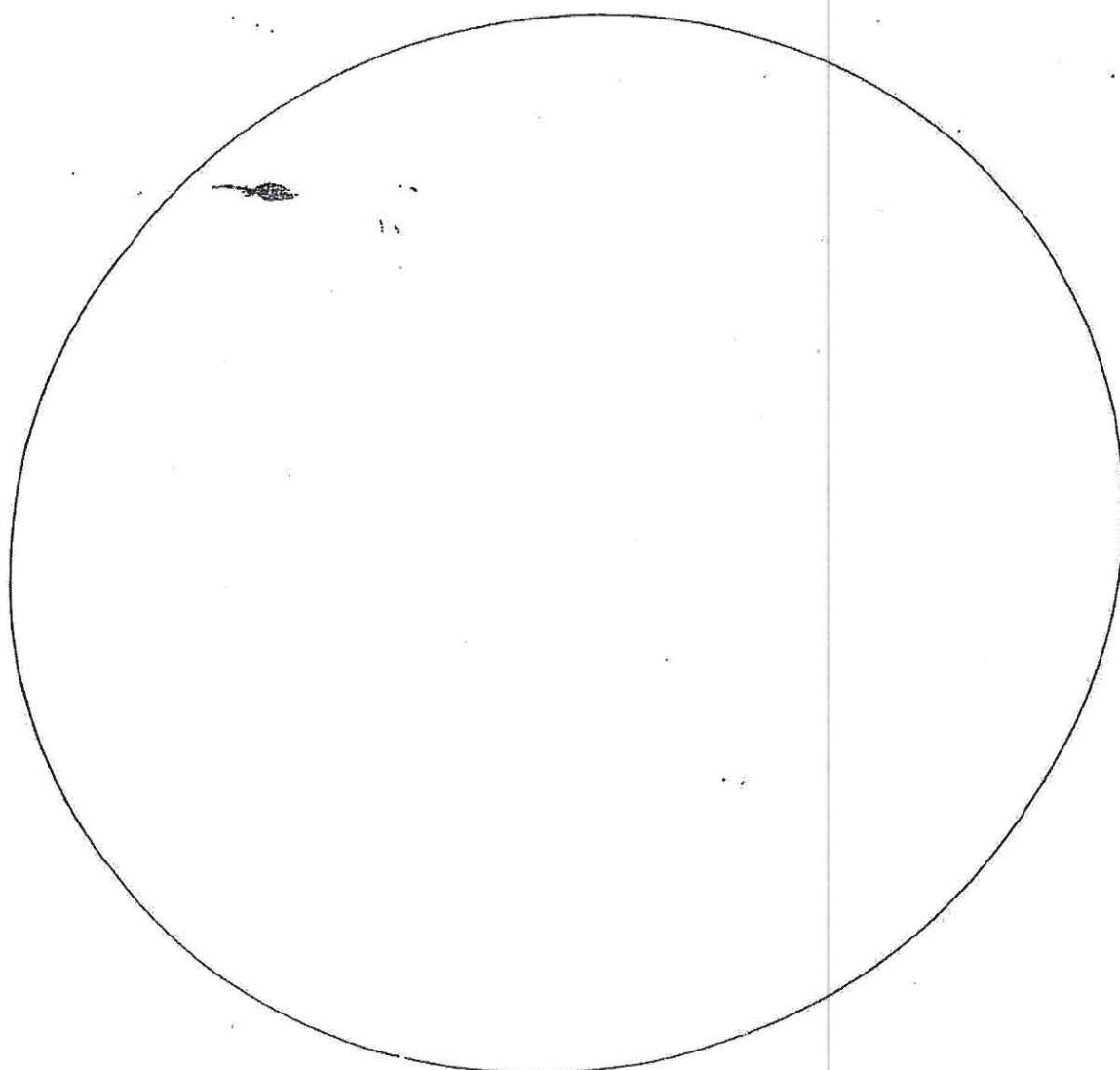


# CLOCK DRAWING

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Instructions:

Put the numbers in the clock and set the time at ten after eleven.



Adapted from Freedman M, Leach L, Kaplan E, Winocur G, Shulman KI, Delis DC. *Clock drawing: A neuropsychological analysis*. New York: Oxford University Press; 1994:46.

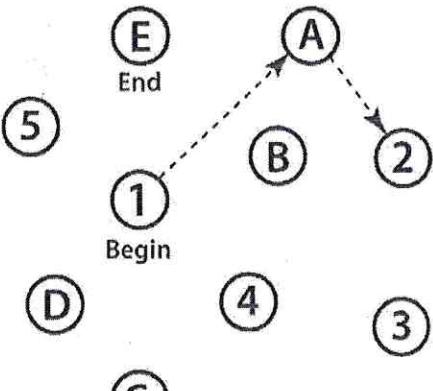
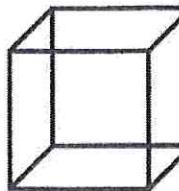
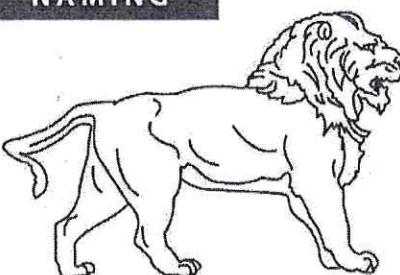
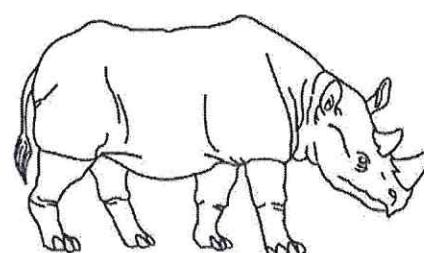
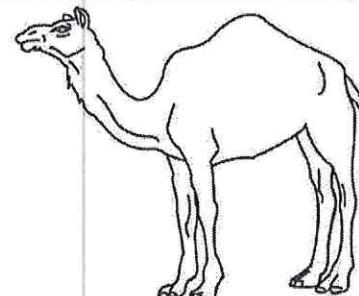
RMLB031004A



MONTREAL COGNITIVE ASSESSMENT (MOCA)  
Version 7.1 Original Version

NAME :  
Education :  
Sex :

Date of birth :  
DATE :

VISUOSPATIAL / EXECUTIVE		Copy cube	Draw CLOCK (Ten past eleven) (3 points)			POINTS							
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Contour							
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbers							
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hands							
						/5							
NAMING													
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		/3							
MEMORY		Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.		FACE	VELVET	CHURCH	DAISY	RED	No points				
				1st trial									
				2nd trial									
ATTENTION		Read list of digits (1 digit/ sec.).		Subject has to repeat them in the forward order			2	1	8	5	4	/2	
				Subject has to repeat them in the backward order			7	4	2				
Read list of letters. The subject must tap with his hand at each letter A. No points if $\geq 2$ errors											/1		
													
Serial 7 subtraction starting at 100		<input type="checkbox"/> 93	<input type="checkbox"/> 86	<input type="checkbox"/> 79	<input type="checkbox"/> 72	<input type="checkbox"/> 65	4 or 5 correct subtractions: 3 pts, 2 or 3 correct: 2 pts, 1 correct: 1 pt, 0 correct: 0 pt					/3	
LANGUAGE		Repeat: I only know that John is the one to help today. <input type="checkbox"/> The cat always hid under the couch when dogs were in the room. <input type="checkbox"/>										/2	
Fluency / Name maximum number of words in one minute that begin with the letter F										<input type="checkbox"/> (N $\geq 11$ words)	/1		
ABSTRACTION		Similarity between e.g. banana - orange = fruit								<input type="checkbox"/> train - bicycle	<input type="checkbox"/> watch - ruler		/2
DELAYED RECALL		Has to recall words WITH NO CUE		FACE	VELVET	CHURCH	DAISY	RED	Points for UNCUED recall only				/5
Optional		Category cue		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
ORIENTATION		<input type="checkbox"/> Date	<input type="checkbox"/> Month	<input type="checkbox"/> Year	<input type="checkbox"/> Day	<input type="checkbox"/> Place	<input type="checkbox"/> City					/6	
© Z.Nasreddine MD										<a href="http://www.mocatest.org">www.mocatest.org</a>	Normal $\geq 26 / 30$	TOTAL <input type="checkbox"/> /30	
Administered by: _____										Add 1 point if $\leq 12$ yr edu			