



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 Monthly _____ Annually _____

(Use present income)

Canada Pension Monthly _____ Annually _____

Other Pension Monthly _____ Annually _____

Other Income Monthly _____ Annually _____

Totals Monthly _____ Annually _____

Total Gross Income appearing on your last income tax return

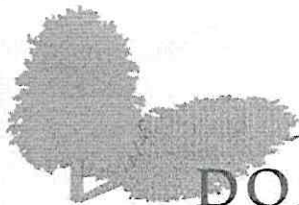
Please list all medications you are currently taking:

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



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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:	Yes	No	Significant Results
-------------------------------	-----	----	---------------------

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:

	Yes	No	Comments
--	-----	----	----------

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 _____

Agression / Acting Out _____

Bowel / Bladder Incontinence _____

History of:

Hep A, B, C _____

AIDS / HIV _____

Tuberculosis _____

OTHER SIGNIFICANT HISTORY**PHYSICIANS SIGNATURE:** _____**CONSENT:**

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.

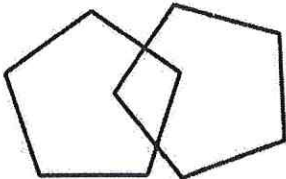
Writing: On the back of the MMSE page, ask the patient to write a sentence for you. Do not dictate a sentence; it is to be written spontaneously by the patient. It must contain a subject and verb and be sensible. Correct grammar and punctuation are not necessary.
Score 1 point only for a correct sentence.

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		
		ORIENTATION
5	()	What (year) (season) (date) (day) (month) is it? (1 point for each correct answer.)
5	()	Where are we: (province) (country) (town or city) (hospital or clinic) (floor)? (1 point for each correct answer.)
		REGISTRATION
3	()	Listen to the following: "apple," "table," "penny." Repeat all 3. (1 point for each correct answer.)
# Trials:	()	(Repeat the objects until the patient learns all 3. Make a maximum of 6 trials. Record the number of trials.)
		ATTENTION AND CALCULATION
5	()	Spell "world" backwards. (1 point for each letter in correct order.) Alternate: Subtract 7 from 100. Take the result and subtract 7 from that. Continue until I ask you to stop. (Continue for 5 subtractions. 1 point for each correct subtraction.)
		RECALL
3	()	What were the 3 objects we repeated earlier? (1 point for each correct answer.) (Note: Recall cannot be tested if all 3 objects were not remembered during registration.)
		LANGUAGE
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. (1 point for each section of the command performed.)
		READ AND OBEY
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:
		 <p>No construction problem</p>
Total score (max. score 30)		

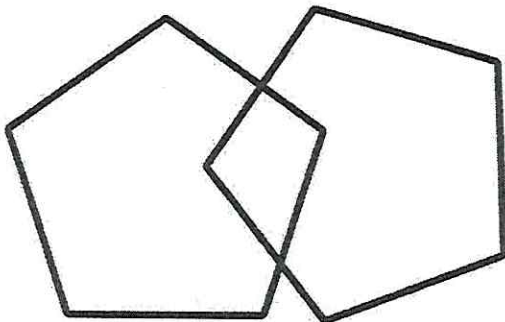
Mini-Mental State Examination (MMSE)

READING:

Close your eyes.

WRITING:

COPYING:

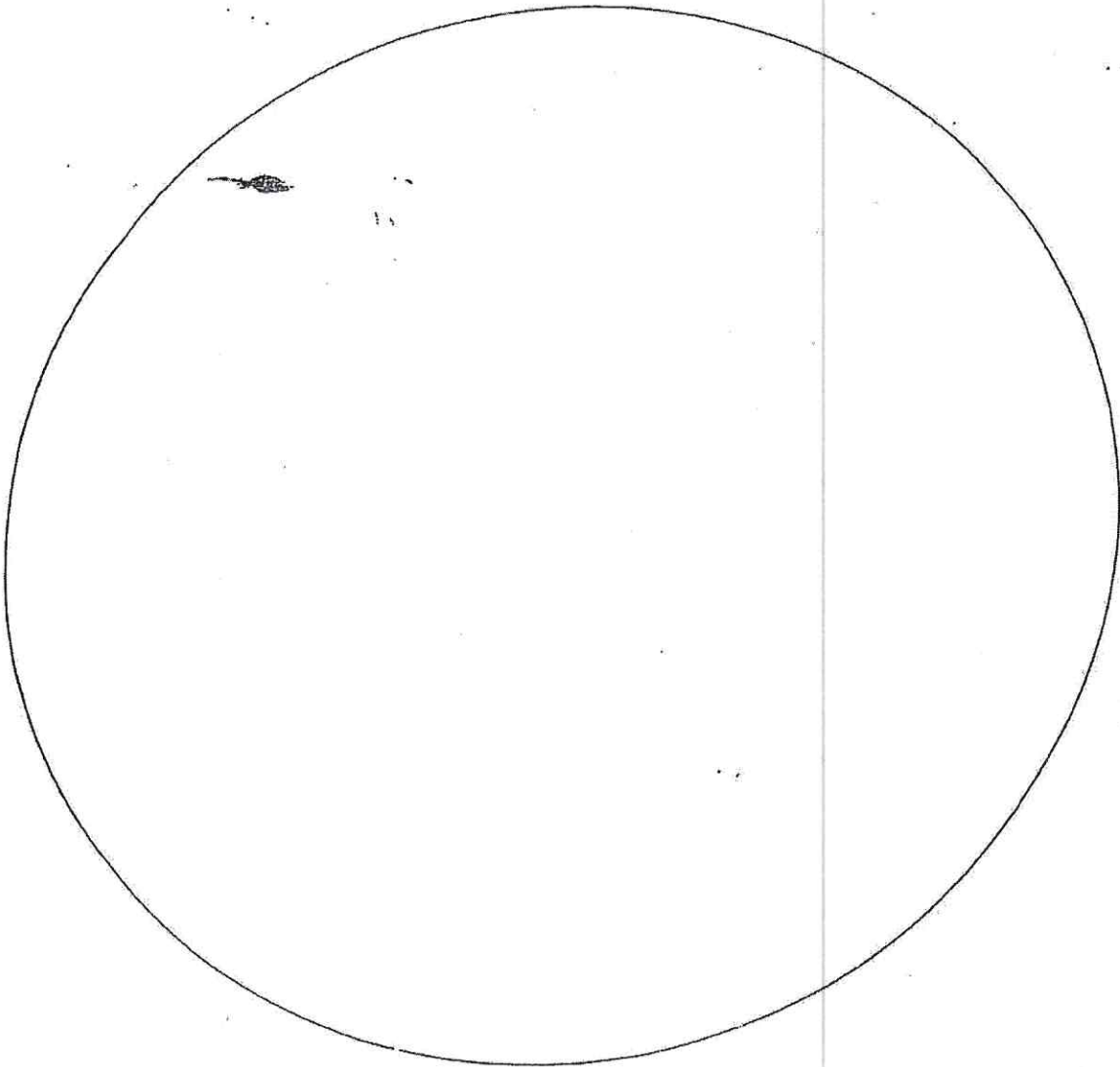


CLOCK DRAWING

Patient's Name _____ Date _____

Instructions:

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



MONTREALSKA LESTVICA SPOZNAVNIH SPOSOBNOSTI
(MoCA - Slovenska)

IME :

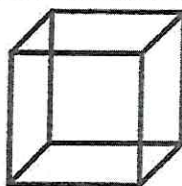
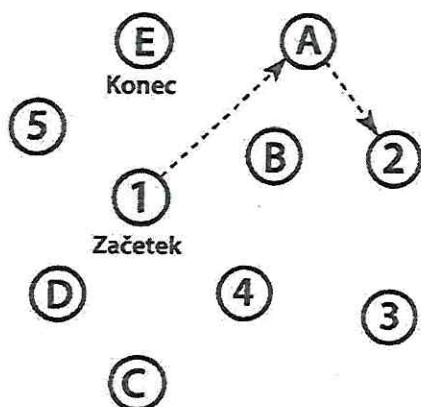
Izobrazba :

Spol :

Datum rojstva :

Datum preizkusa :

VIDNOPROSTORSKE / IZVRŠILNE



Prerišite
kocko

Narišite URO (naj kaže deset čez enajst)
(3 točke)

TOČKE

[]

[]

[]

[]

[]

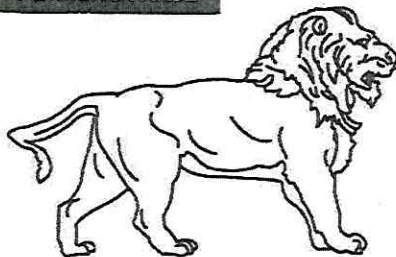
___/5

Oblika

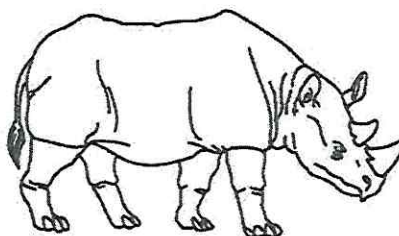
Številke

Kazalca

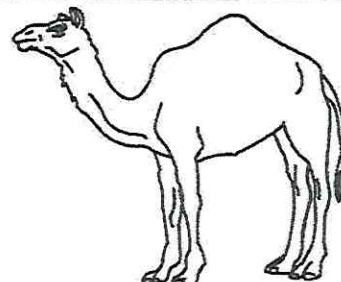
POIMENOVANJE



[]



[]



[]

___/3

SPOMIN

Preberite seznam besed,
preiskovanec naj jih ponovi za vami. Opravite dva
poskusa ponavljanja, tudi če je bil prvi povsem uspešen.
Poskus priklica besed opravite po 5 minutah.

	OBRAZ	ŽAMET	CERKEV	MARJETICA	RDEČ
1. poskus					
2. poskus					

Ni
točk

POZORNOST

Preberite seznam števil
(1 številka / sekundo)

Preiskovanec naj jih ponovi v enakem vrstnem redu [] 2 1 8 5 4
Preiskovanec naj jih ponovi v obratnem vrstnem redu [] 7 4 2

___/2

Berite seznam črk (1 črka na sekundo). Preiskovanec naj
potoľče z roko, kadarkoli sliši črko A.

Ni točk ≥ 2 napaki.

[] FBACMNAAJKLBAFAKDEAAAJAMOF AAB

___/1

Zaporedno odštevanje po 7, začne pri 100

[] 93

[] 86

[] 79

[] 72

[] 65

4 ali 5 praviľnih odštevanj : 3 točke, 2 ali 3 praviľni : 2 točki, 1 praviľno : 1 točka, 0 praviľnih : 0 točk

___/3

JEZIK

Ponovite : " Vem samo to, da je Peter danes na vrsti za pomagat. " []
" Mačka je vedno zbežala pod kavč, ko so bili v sobi psi. " []

___/2

Fluentnost : V eni minuti naj pove čimveč besed, ki se začnejo na črko S :

[] ____ (N ≥ 11 besed)

___/1

ABSTRAKCIJA

Kaj imata skupnega banana - pomaranča (= sadje) [] vlak - bicikel [] ura - ravnilo []

___/2

ODLOŽENI PRIKLIC

Prikljče besede
BREZ IZTOČNICE

OBRAZ
[]

ŽAMET
[]

CERKEV
[]

MARJETICA
[]

RDEČ
[]

Točke le za
odloženi priklic
BREZ IZTOČNICE

___/5

5 kategorialno iztočnico

Z izbiri med več možnostmi

ORIENTACIJA

[] Datum

[] Mesec

[] Leto

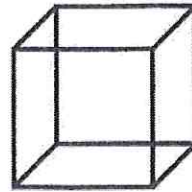
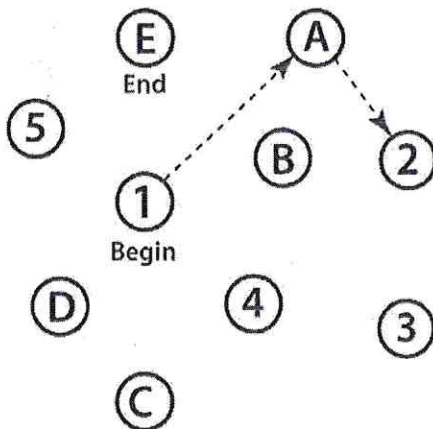
[] Dan

[] Kje smo

[] Mesto

___/6

VISUOSPATIAL / EXECUTIVE



Copy
cube

Draw CLOCK (Ten past eleven)
(3 points)

POINTS

[]

[]

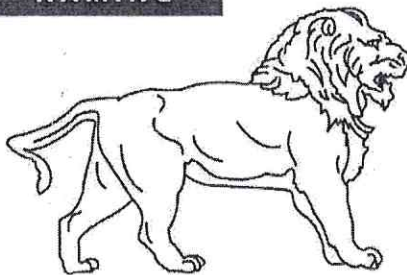
[]
Contour

[]
Numbers

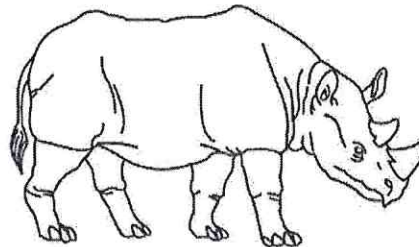
[]
Hands

___/5

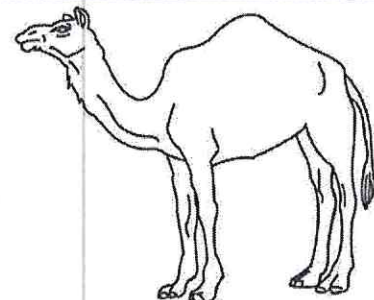
NAMING



[]



[]



[]

___/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
1st trial					
2nd trial					

No
points

ATTENTION

Read list of digits (1 digit/ sec.).

Subject has to repeat them in the forward order

[] 2 1 8 5 4

Subject has to repeat them in the backward order

[] 7 4 2

___/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors

[] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

___/1

Serial 7 subtraction starting at 100

[] 93

[] 86

[] 79

[] 72

[] 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. []

The cat always hid under the couch when dogs were in the room. []

___/2

Fluency / Name maximum number of words in one minute that begin with the letter F

[] _____ (N \geq 11 words)

___/1

ABSTRACTION

Similarity between e.g. banana - orange = fruit

[] train - bicycle

[] 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

Multiple choice cue

ORIENTATION

[] Date

[] Month

[] Year

[] Day

[] Place

[] City

___/6