



Charitable Number:  
11915-2064 RR 001

SLOVENIAN LINDEN FOUNDATION

52 Neilson Drive,  
Etobicoke, Ontario  
M9C 1V7  
Telephone: (416) 621-3820  
Fax: (416) 621-9773  
e-mail: info@domlipa.ca  
website: www.domlipa.ca

## 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: ( \_\_\_\_\_ ) \_\_\_\_\_

Business: ( \_\_\_\_\_ ) \_\_\_\_\_

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

Address \_\_\_\_\_

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

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

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

Business: ( \_\_\_\_\_ ) \_\_\_\_\_

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 \_\_\_\_\_

\*Please provide us with an email to contact regarding acceptance/rejection of application:

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

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:

YesNoSignificant 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:**YesNoComments

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.*

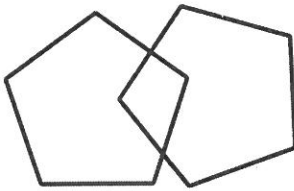
**Writing:** On the back of the MMSE page, ask the patient to write a sentence for you. Do not dictate a sentence; it is to be written spontaneously by the patient. It must contain a subject and verb and be sensible. Correct grammar and punctuation are not necessary.  
*Score 1 point only for a correct 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		
		<b>ORIENTATION</b>
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.)
		<b>REGISTRATION</b>
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.)
		<b>ATTENTION AND CALCULATION</b>
5	( )	Spell "world" backwards. (1 point for each letter in correct order.) <b>Alternate:</b> 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.)
		<b>RECALL</b>
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.)
		<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. (1 point for each section of the command performed.)
		<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)		



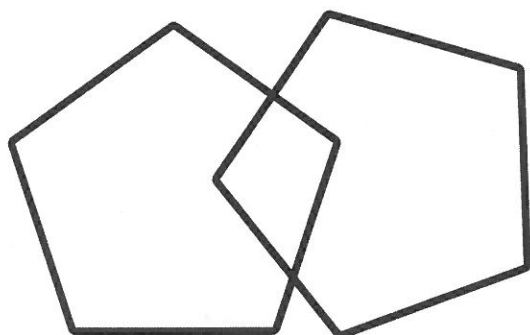
## Mini-Mental State Examination (MMSE)

### READING:

Close your eyes.

### WRITING:

### COPYING:

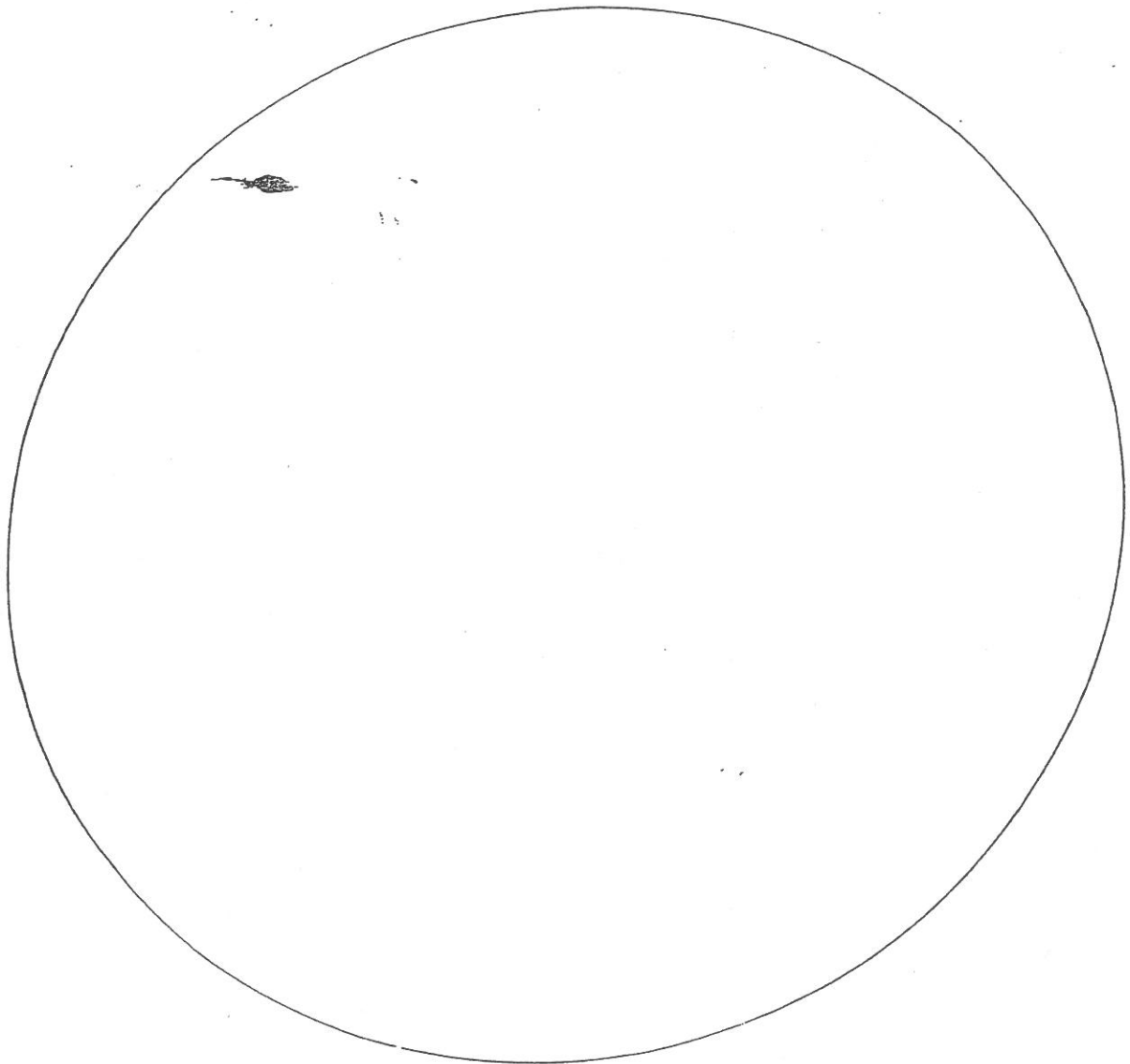


# CLOCK DRAWING

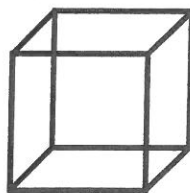
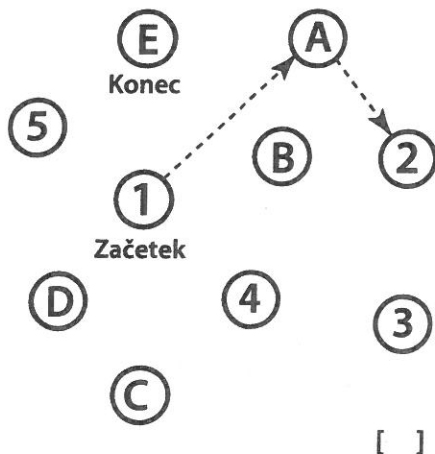
Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Instructions:

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



VIDNOPROSTORSKE / IZVRŠILNE



Prerišite  
kocko

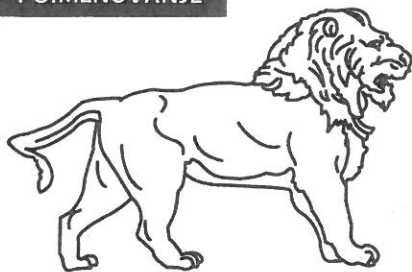
Narišite URO (naj kaže deset čez enajst)  
(3 točke)

TOČKE

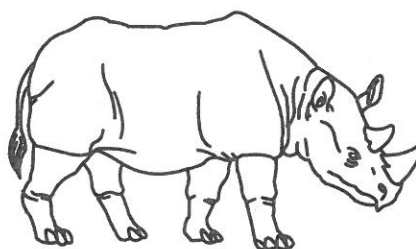
[ ] [ ] [ ]  
Oblika Številke Kazalca

\_\_\_/5

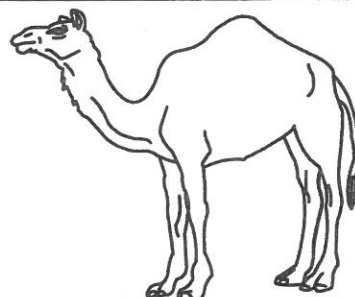
POIMENOVANJE



[ ]



[ ]



[ ]

\_\_\_/3

S P O M I N

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  
potočje 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 pravih odštevanj : 3 točke, 2 ali 3 pravih : 2 točki, 1 pravih : 1 točka, 0 pravih : 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

Prikliče besede  
BREZ IZTOČNICE

OBRAZ  
[ ]

ŽAMET  
[ ]

CERKEV  
[ ]

MARJETICA  
[ ]

RDEČ  
[ ]

Točke le za  
odloženi priklic  
BREZ IZTOČNICE

\_\_\_/5

S kategorialno iztočnico

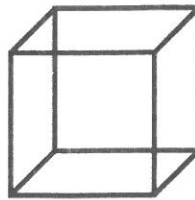
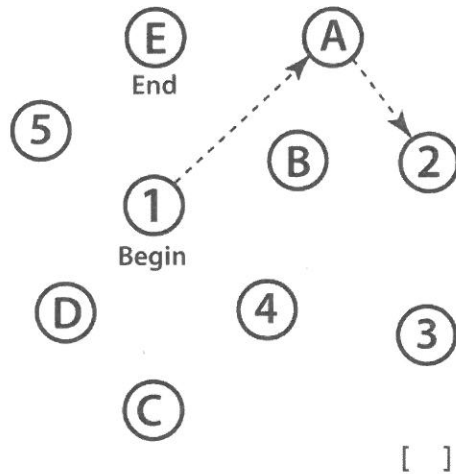
Z izbiro med več možnostmi

ORIENTACIJA

[ ] Datum [ ] Mesec [ ] Leto [ ] Dan [ ] Kje smo [ ] Mesto

\_\_\_/6

**VISUOSPATIAL / EXECUTIVE**



Copy  
cube

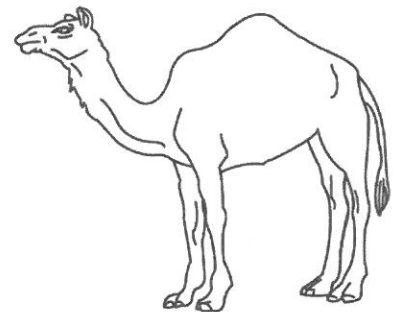
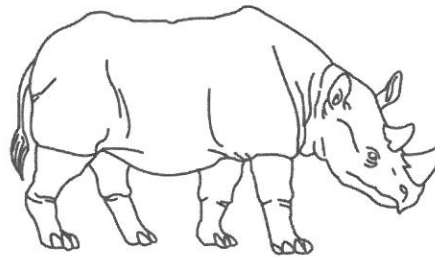
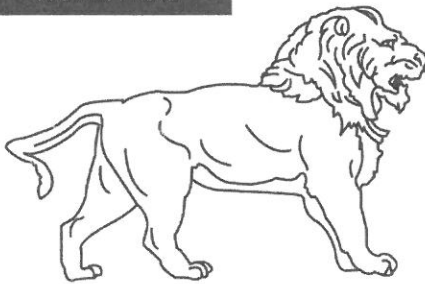
Draw CLOCK (Ten past eleven)  
(3 points)

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  $\geq 2$  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