

*Central Carleton Nursing Home Foundation, Inc.*



**APPLICATION FOR RESIDENCY**

Please return completed applications to:

Carleton Place  
139 Rockland Road  
Hartland, NB E7P 1E9  
[info@ccnh.ca](mailto:info@ccnh.ca)

**Page 1 – Contact Information**

1. Date of Application: \_\_\_\_\_

2. Applicant Names: a) \_\_\_\_\_

b) \_\_\_\_\_

3. Present Address: \_\_\_\_\_

\_\_\_\_\_

4. Telephone Number: \_\_\_\_\_

5. References: a) \_\_\_\_\_ Phone #: \_\_\_\_\_

b) \_\_\_\_\_ Phone #: \_\_\_\_\_

6. Family Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

*Carleton Place*

**Page 2: General Information**

1) Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

2) Can the applicant move around unaided? Yes \_\_\_ No \_\_\_ (walker, cane, \_\_\_\_\_)

b) Can the applicant get up and down from chairs and sofas unaided?  
Yes \_\_\_ No \_\_\_

3) Can the applicant safely administer their own medications?  
Yes \_\_\_ No \_\_\_

4) Is the applicant able to attend to their own personal needs, such as bathing, brushing teeth, etc.? Yes \_\_\_ No \_\_\_ (If no, does the applicant have a home care attendant to assist with personal needs? Yes \_\_\_ No \_\_\_ )

5) Are there any medical conditions that staff should be aware of? (i.e. has the applicant had a recent flu vaccine, and was there any reaction to it?) Yes \_\_\_ No \_\_\_  
If yes, please explain

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6) Who is the applicant's family physician? \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Page 3: Dietary Profile**

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

Special Diet: \_\_\_\_\_

Food Allergies: \_\_\_\_\_

Problem Foods: \_\_\_\_\_

Food Likes: \_\_\_\_\_

Food Dislikes: \_\_\_\_\_

Portion Size:      LARGE \_\_\_\_\_      REGULAR \_\_\_\_\_      SMALL \_\_\_\_\_

Texture:            REGULAR \_\_\_\_\_      CUT SMALL \_\_\_\_\_      GROUND \_\_\_\_\_

Eating aids needed? \_\_\_\_\_

**FOOD ITEMS DESIRED BETWEEN MEALS:**

Mid AM: \_\_\_\_\_

Mid PM: \_\_\_\_\_

Bedtime: \_\_\_\_\_

VIAL FOR LIFE – INFORMATION RECORD

*Please note that all information disclosed on this form will be kept confidential and will only be utilized in the event of an emergency.*

Name: \_\_\_\_\_ Medicare: \_\_\_\_\_ Exp \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_ (375-3006)

Address: Carleton Place, 135 Rockland Rd, Hartland, NB E7P 1E9, Unit #

Family Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Person to be notified: Name \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone Number(s) \_\_\_\_\_

Current Medical Conditions \_\_\_\_\_

\_\_\_\_\_

List of Medications: Dosage & Frequency \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies or Sensitivities to Medications \_\_\_\_\_

\_\_\_\_\_

Any other Pertinent Health Information, such as past medical highlights/  
hospitalizations, contact lenses, false teeth, artificial limbs, health directives, etc:

\_\_\_\_\_

Date Completed (or last date reviewed) \_\_\_\_\_

*Please update each time medical information changes and review annually.*