

# MEDICAL REPORT

MEDICAL REPORT TO BE COMPLETED BY MEDICAL PRACTITIONER IN RESPECT OF AN APPLICATION FOR ADMISSION TO AN OLD AGE HOME.

*Please complete all sections of this form. The information is required to facilitate nursing and administrative arrangements. Unfavourable replies will not exclude the applicant from admission.*

NAME .....

DATE OF BIRTH .....

1. GENERAL PHYSICAL AND PSYCHOLOGICAL CONDITION:

(a) Physical and Nutritional state .....

.....

(b) Presence of Contagious Disease Yes/No .....

(c) Nature and Date of Surgical Operations .....

.....

.....

(d) Mental Ability:

Good	
Reasonable	
Poor	

2. INDEPENDENCE:

(a) Mobility:

Completely Mobile	
Walking Aid	
Wheelchair	
Bedridden/Staff Dependent	

(b) Bathing:

Can Manage Alone	
Requires Some Assistance	
Must Be Bathed	

(c) Dressing:

Independent	
Needs Some Help	
Must Be Dressed	

3. CARDIO-VASCULAR:

- (a) Blood Pressure ..... Pulse .....
- (b) Is patient on Beta/Blockers? Yes/No .....  
If Yes, Medication .....
- (c) Hypertension and Medication .....
- (d) Has patient ever had Myocardial/Ischemic Episodes? Yes/No .....  
.....
- (e) Is there Heart failure?.....

4. RESPIRATORY SYSTEM:

- (a) Respiratory or Cardiac Asthma? Yes/No .....
- (b) Chronic Bronchitis? Yes/No .....
- (c) Emphysema/C.O.A.D.? Yes/No .....
- (d) P.T.B.? Yes/No .....  
Medication .....
- (e) Other: (specify) .....  
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5. DIGESTIVE SYSTEM:

- (a) Diabetes .....
- (b) Liver Ailments .....
- (c) Gastric/Duodenal Ulcer .....
- (d) Intestines .....
- (e) Hernia .....
- (f) Constipation .....
- (g) Other: (specify) .....
- (h) Special Diet: (specify) .....
- (i) Weight .....

6. UROGENITAL SYSTEM:

- (a) Incontinence Yes/No .....  
Degree of Incontinence .....  
Indwelling Catheter Yes/No .....  
Permanent/temporary .....
- (b) Urine: Macroscopic and Microscopic (specify results) .....  
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7. CENTRAL NERVOUS SYSTEM: (NB Please answer all questions in full)

- (a) Epilepsy Yes/No .....  
Nature of Attack .....  
Medication .....
- (b) Parkinson's Disease Yes/No .....  
Medication .....
- (c) Cerebrovascular Accident .....  
.....
- (d) Senility Yes/No .....
  - (i) Nature and degree .....  
Mini-mental (if possible) .....
  - (ii) Loss of Memory .....
  - (iii) Restlessness/Wandering .....
  - (iv) Aggressive Yes/No (specify) .....
  - (v) Disorientated (in terms of time, place, person) .....  
.....
  - (vi) Behavioural Changes .....  
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  - (vii) Depression Yes/No .....  
Medication (specify) .....
- (e) Other (specify) .....  
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8. SENSORY ABILITY:

- (a) Hearing .....  
Hearing Aid .....
- (b) Eyesight .....  
Spectacles .....

9. SKELETAL AND SKIN INTEGRITY:

- (a) Arthritis: Yes/No (specify) .....  
Medication (and/or reaction to) .....
- (b) Ulcers (specify with treatment) .....
- (c) Eczema (specify with treatment) .....  
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- 10. IS THERE A SUSPICION OF NEOPLASM? Yes/No .....  
If Yes, specify with Treatment .....  
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- 11. ANY OTHER CONDITION PRESENT? .....  
.....  
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- 12. PLEASE ATTACH RELEVANT SPECIALISTS/INVESTIGATION REPORTS.
- 13. PRESCRIBED MEDICATION (current) .....  
.....  
.....
- 14. ALLERGIES (specify)
  - (a) To Foods .....
  - (b) Medication .....
  - (c) Treatment/Dressings .....
- 15. IS PATIENT ATTENDING AN OUTPATIENT CLINIC? Yes/No .....  
If Yes, specify .....
- 16. GENERAL COMMENTS .....
- 17. HOW LONG HAS PATIENT BEEN UNDER YOUR CARE? .....
- 18. GENERAL PRACTITIONER (print in block letters).....  
ADDRESS .....  
.....  
TELEPHONE (Surgery) .....  
TELEPHONE (Home/After Hours) .....  
CELLULAR .....