ANNEXURE A

MEDICAL REPORT

MEDICAL REPORT TO BE COMPLETED BY YOUR MEDICAL PRACTITIONER IN RESPECT OF AN APPLICATION 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. Unfavorable replies will not exclude the applicant from admission.

NAME .....

DATE OF BIRTH …… AGE .....,

1. APPLICANT'S HEALTH STATUS (DIAGNOSIS)

   …….....

   .....

   .....

   .....

2. ALLERGIES.....

   .....

   .....

3. PRESENT MEDICATION AND DOSAGE …….....

   .....

   .....

   .....

4. OTHER TREATMENT REQUIRED .....

   .....

   .....

5. GENERAL PHYSICAL AND NUTRITIONAL STATE ….....

   .....

6. RESPIRATORY SYSTEM .....

   P.T.B.

Yes		No	

   MEDICATION .....

7. CARDIOVASULAR SYSTEM .....

   .....

   .....

8. BLOOD PRESSURE .....
9. GENITO-URINARY SYSTEM .....

INCONTINENCE:

Yes		No		Partial	

Urine		Stools		Both	

URINE TO BE TESTED IN ALL CASES …….....

10. DIGESTIVE SYSTEM .....

.....

WEIGHT OF PATIENT …….....

11. MUSCULAR AND SKELETAL SYSTEM …….....

.....

12. CENTRAL NERVOUS SYSTEM .....

EPILEPSY (please state type, severity and frequency of attacks) .....

.....

CEREBROVASCULAR ACCIDENT …….....

.....

PARKINSON'S DISEASE .....

13. MENTAL CONDITION OF PATIENT

Normal		Memory Loss		Senile		Confused		Aggressive	

.....

.....

.....

14. IS THE APPLICANT FREE OF ANY INFECTION OR CONTAGIOUS DISEASES?

Yes		No	

If No, please provide full

details.....

.....

.....

15. VISION

Good		Fair		Blind	

SPECTACLES

Yes		No	

16. HEARING

Good		Poor		Deaf	

HEARING AIDS?

Yes		No	

17. IS THE PATIENT BEDRIDDEN?

Yes		No	

If No, is the patient able to walk Independently or with assistance? …….....

……..……

18. IS THE PATIENT IN NEED OF NURSING CARE?

Yes		No	

If No, why does he/she need admission to an Old Age Home? …….....

……..…….

If Yes, what care is needed?

Regular		Irregular		Constant	

……

……

19. DOES THE APPLICANT REQUIRE ASSISTANCE WITH ANY OF THE FOLLOWING?

DRESSING

Yes		No	

DETAILS

……..

FEEDING

Yes		No	

DETAILS

……..

PERSONAL HYGIENE

Yes		No	

DETAILS

……..

20. HAVE ANY SPECIAL TESTS BEEN CARRIED OUT?

Yes		No	

WHICH TESTS HAVE BEEN DONE? .....

IMPORTANT: PLEASE ATTACH COPIES OF TESTS RESULTS.

21. HOW LONG HAS THE PATIENT BEEN UNDER YOU CARE? .....

22. DEGREE OF DISABLEMENT

Slight		Moderate		Severe	

23. PROGNOSIS

……..

24. ADDITIONAL REMARKS/MOTIVATION FOR ADMISSION ……..……..

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MEDICAL PRACTIONER
(PLEASE PRINT)

SIGNATURE

……..…….....

TELEPHONE NUMBER

ADDRESS

……..…….....

……..…….....

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……..…….....

……..…….....

DATE