

MEDICAL REPORT FOR ADMISSION TO HOME/IMPAIRED DIVISION

1. **FULL NAME AND SURNAME:** _____

2. **AGE:** _____

3. **APPLICANT'S MEDICAL HISTORY AND PREVIOUS TREATMENT:**

4. **GENERAL EXAMINATION:**

Blood pressure reading:

HB reading:

HGT reading:

4.1 **General bodily condition**

4.2 **Respiratory System**

4.3 **Heart and Circulatory System**

4.4 **Urinary System (Urine test please)**

INCONTINENT	Yes	No
--------------------	-----	----

If "Yes," specify Incontinent Products:

4.5 Digestion and other abdominal systems

4.6 Muscle and skeletal system (state any deviations)

4.7 Central nervous system

4.8 Endocrine system

4.8 Other conditions (Does the patient suffer from any of the following?)

Rheumatism ☐ Chronical osteoarthritis ☐ Venereal disease ☐
 Myopathy ☐ Previous Hemiplegia ☐ Infectious Diseases ☐
 Parkinson ☐ Skin diseases ☐ Cerebral atrophy ☐ Allergies ☐

4.9 Does the applicant control his/her excretion functions?

Yes ☐ No ☐

4.10 Does the applicant have problems with:

(Remarks)

Speech ☐
 Balance ☐
 Hearing ☐
 Sight ☐
 Taste ☐

4.11 Cancer history: (Please describe)

4.12 Indicate:

PRIVATE Patient		STATE Patient	
DURATION OF TREATMENT:			

5. **HEALTH (make crosses where applicable. If n/a left box open)**

5.1	MENTAL HEALTH	
	Hallucinations/Delirium	
	Persecution Delusion	
	Other: <i>(Describe)</i>	

5.2	ANXIETY	
	Psychosomatic	
	Obsessive-Compulsive	
	Hysteria	
	Phobias	

5.3	DEPRESSION	
	Moderately	
	Serious	
	Endogenous	

5.4	DEMENTIA	
	Vascular Dementia	
	Alzheimer's	
	Other: Specify	

5.5	PERSONALITY DISORDERS	
	Passive dependent	
	Passive aggression	

General remarks regarding the above:

.....

.....

.....

5.6	DRUG DEPENDENCE OR ABUSE (specify, e.g. Alcohol/medication).....	
Social		
Chronic		

5.7	EPILEPSY	YES		NO	
-----	-----------------	------------	--	-----------	--

Remark: (indicating type of medication)

5.8	INTELLECTUAL IMPAIRMENT	YES		NO	
-----	------------------------------------	------------	--	-----------	--

Remark:

6. CURRENT PSYCHIC/PHYSICAL FUNCTIONING

6.1 Personal Functioning:

6.2 Orientation regarding change:

6.3 Communication proficiency: (Please describe) -

6.4 Consciousness level: (indicate)

Awake ☐ Apathetic ☐ Sleepy ☐ B ☐ ed ☐ Pass ☐ ☐

Remarks: _____

6.5 Behavior:

6.6 Does the applicant regularly need help in regard to his/her mobility, clothing, nutrition, medication and personal hygiene? (Please describe fully where applicable)

Mobility:

[a] Permanently bedridden ☐ [b] Wheelchair bound ☐
[c] Medical aids ☐

Clothing:

Nutrition:

Medication:

Personal Hygiene:

Skin conditions (e.g. pressure ulcers/ulcers/scabies):

7. **CHRONIC MEDICINE CURRENTLY IN USE/DOSAGE** (Specify in respect of physical and mental health)

8. **HOW LONG DO YOU TREAT THE PATIENT?** _____
And, if so, briefly indicate the nature and extent of the treatment:

9. **GENERAL REMARKS:**

PHYSICIAN
[PRINTING SCRIPT]

PHYSICIAN
[SIGNATURE]

DATE

Address:

Tel no:

Practice no:

E-mail Address:
