TO BE COMPLETED BY MEDICAL PRACTITIONER ONLY

MEDICAL REPORT IN RESPECT OF RYNPARK LIFE RIGHT AGREEMENT

Full Name:			
Date of Birth:			
Identity Number:			
Age:		**Gender:**	

1. GENERAL EXAMINATION

1.1 SENSES

1.1.1 Vision

Eyesight: ***GOOD / REASONABLE / POOR / BLIND***

Eye Disorders/Problems/Complaints _____

Special eye care/Assistive devices _____

1.1.2 Hearing

Ability: ***GOOD / REASONABLE / POOR / DEAF***

Ear Disorders/Problems/Complaints _____

Special care /Assistive devices _____

1.1.3 Touch

Sense of feeling: ***GOOD / FAIR / POOR / ABSENT***

Skin Colour: ***NORMAL / FLUSHED / PALE / CYANOTIC / YELLOW***

Skin conditions/problems/complaints _____

Hair or scalp conditions/problems _____

1.1.4 Taste

Ability: ***GOOD / FAIR / POOR / ABSENT***

Tongue conditions/problems/complaints _____

1.1.5 Smell

Ability: ***GOOD / FAIR / POOR / ABSENT***

Nose problems/conditions/complaints _____

1.2 SYSTEMS

1.2.1 Muscular/Skeletal

Length: _____

General posture and mobility: ***UPRIGHT / STOOPED / WALKS WITH EASE / WALKS WITH DIFFICULTY / WHEELCHAIR / WALKING FRAME / STICK / PROSTHESIS / BEDRIDDEN***
Joint and muscle movement: ***FREE MOVEMENT / LIMITED / ATROPHY / PARALYSIS / SPASTICITY / CONTRACTURES***

Joint and muscle problems/complaints _____

Extremities:- _____

Arms: _____

FUNCTIONAL L/R / LIMITED L/R / NON-FUNCTIONAL L/R

Problems/complaints _____

Hands : _____

FUNCTIONAL L/R / LIMITED L/R / NON-FUNCTIONAL L/R

Problems/complaints _____

Legs: _____

FUNCTIONAL L/R / LIMITED L/R / NON-FUNCTIONAL L/R

Problems/complaints _____

Feet: problems/complaints _____

1.2.2 Cardio Vascular

Blood Pressure _____ ***NORMAL / HYPOTENSIVE / HYPERTENSIVE***

Pulse Rate _____ ***STRONG / WEAK / REGULAR / IRREGULAR***

Heart problems/disorders/complaints _____

Special treatment/care _____

1.2.3 Respiratory

Rate _____

Lung disorders/problems/complaints _____

Special treatment/care _____

1.2.4 Gastro Intestinal

Weight _____

NORMAL / OVERWEIGHT / WEIGHT LOSS / WEIGHT FLUCTUATIONS

Nutritional status: ***GOOD / REASONABLE / POOR / VERY POOR***

Appetite: ***GOOD / FAIR / WEAK / EXTREMELY***

Ability to chew & swallow: ***GOOD / PROBLEMS***

Diet (Specify special diet) _____

Food allergies _____

Teeth/dentures _____

Bowel action & control: ***REGULAR / CHANGES / DIARROEA / CONSTIPATION / INCONTINENCE***

Mouth conditions/problems/complaints _____

Throat conditions/problems/complaints _____

Bowel, Gastric, liver, pancreas conditions/problems/complaints _____

_____

Special care/treatment _____

1.2.5 Renal and Urinary

Routine urine test _____

Urinary flow and output: ***NORMAL / INTERRUPTED / RETENTION / FREQUENCY***

Sphincter control: ***COMPLETE / PARTIALLY / INCONTINENCE***

Bladder, kidney disorders/problems/complaints _____

Special treatment/care _____

1.2.6 Reproductive

Female

Breasts _____

Internal reproductive organs _____

External genitalia _____

Gynecological/obstetric history _____

Male

External genitalia _____

Prostate problems/complaints _____

1.2.7 Endocrine

Disorders/problems/complaints:

DIABETES / HYPO / HYPERTHYROIDISM _____

1.2.8 Haematological

Disorders/problems/complaints: ***LEUKEMIA / ANAEMIA / CLOTTING DISORDERS / BLEEDING TENDENCY*** _____

1.2.9 Neurological

Consciousness level: ***ALERT / SLEEPY / SEMI-CONSCIOUS / UNCONSCIOUS***

Pupil reaction: ***REGULAR / IRREGULAR / DILATED / CONSTRICTED***

Speech problems/complaints _____

Neurological disorders/problems/complaints _____

2. MENTAL STATUS

2.1 Orientation

	GOOD	FAIR	POOR	DISORIENTATED
Orientation to place				
Orientation to time				
Orientation to person				

2.2 Memory

	GOOD	FAIR	POOR	TOTAL LOSS
Short term				
Long term				
Intermediate				

2.3 Emotional Status

CALM / RESTLESS / DEPRESSED / ANXIOUS / AGGRESSIVE / TOTAL WITHDRAWAL

_____

2.4 Comprehension

_____

GOOD / FAIR / POOR

_____

2.5 Mental disorders/problems/complaints

_____

_____

_____

_____

2.6 Previous visit to Psychiatrist (Specify when, reason, treatment)

_____

_____

_____

3. SLEEP PATTERN

GOOD / INTERRUPTED / INSOMNIA

Problems/complaints _____

Requires sedation _____

4. HABITS

Smoke/alcohol other substances (specify) _____

_____

5. RISK FACTORS

Allergies, cortisone, anti-coagulants etc. (specify) _____

6. PREVIOUS MEDICAL HISTORY

(State conditions and treatment)

_____

_____

_____

_____

7. PREVIOUS SURGERY

_____

_____

_____

_____

8. PREVIOUS RADIATION

Where (Breast, etc) _____ When: _____

_____

_____

8. PREVIOUS CANCER TREATMENT (CHEMO THERAPY)

_____

_____

9. CURRENT DIAGNOSIS/PROBLEMS/CONDITIONS AND MEDICATION

DIAGNOSIS	MEDICATION	DOSAGE	FREQUENCY

10. Will further treatment improve or cure abovementioned conditions? If "Yes" state what is recommended.

_____

_____

_____

11. Any other condition not included in classification above.

(Infectious or contagious diseases)

_____

_____

12. Does applicant require regular assistance in respect of mobility, dressing, bathing and eating?

_____

13. GENERAL REMARKS

_____

_____

_____

_____

14. NAME AND QUALIFICATION OF MEDICAL PRACTITIONER

_____

SIGNATURE: _____

ADDRESS: _____

TEL. NO: _____

PERIOD OVER WHICH I HAVE KNOWN/TREATED THE APPLICANT: _____

PLACE: _____ **DATE:** _____

MEDICAL PRACTITIONER STAMP

15. APPLICANT

"The Resident confirms that the medical information provided to the Association at the time of entering into the agreement regarding his / her health condition, mental as well as his / her physical abilities, is true and correct. The Resident further confirms that he / she can function independently."

NAME:			
SIGNATURE:			
ADDRESS:			
TEL. NO:			
PLACE:		**DATE:**	