HELPENDE HANDE FRAIL CARE CENTRE
Ward 19 | Stikland Hospital Grounds | De la Haye Rd | Bellville | 7530
Tel: 021 919 5684 | Cell: 083 742 6490 | Fax: 021 910 0821
mail: helpendehandeversorging@gmail.com | Web: www.helpendehande.co.za

ADMISSION APPLICATION MEDICAL REPORT

This medical report has to be completed by the Patient's Medical Practitioner and is a compulsory requirement that has to accompany Helpende Hande Frail Care Centre's Admission Application form.

Patient Information

Surname		**Age**	
Full Names			

Applicant's Health Condition [History | Symptoms | Treatment]

....

....

....

....

....

....

General examination

1.1	General Health Condition	
1.2	Respiratory System	
1.3	Heart & blood vessels	
1.4	Blood Pressure	

1.5	Urine & Sex Organs [Conduct Urine Test Please]	
1.6	Digestive & Abdominal systems	
1.7	Skeletal & Muscle system [mention deformities]	
1.8	Central Nervous System	

1.9 Psychological Wellbeing - Does the patient suffer from any of the following conditions?

Depression		Senile Dementia		Psychotic Necrosis		Aggressiveness		Are there specific Care requirements that Helpende Hande would need to assist with?		
Y	N	Y	N	Y	N	Y	N	Y	N	

Please describe the condition and advise the type of Care Requirements:

1.10 Other Conditions: Does the patient suffer from any of the following conditions?

Arthritis		Chronic Osteoarthritis		Tabes Dorsalis		Myopathy		Cerebral Atrophy	
Y	N	Y	N	Y	N	Y	N	Y	N
Parkinson's disease		Skin Disease		Allergies		Infectious Disease		Hemiplegia	
Y	N	Y	M	Y	N	Y	N	Y	N

1.11 Bowel Movements: Does the patient have control over their bowel movements?

1.12 Does the patient have issues with:

Hearing	Y	N	Eyesight	Y	N	Speech	Y	N

1.13 Does the patient have any malignant tumours diagnosed? Please describe:

1.14 Does the Patient suffer from any Alcohol or Drug abuse conditions? Please describe:						
1.15 Does the Patient have a smoking history?	Y	N	For how Long?			
1.16 Does the Patient currently smoke?	Y	N				
1.17 Is the Patient permanently bedridden?	Y	N	Wheelchair bound?		Y	N

1.18 Does the Patient constantly require assistance with? Please describe details where relevant.			
Mobility	Y	N	
Clothing	Y	N	
Feeding	Y	N	
Medication	Y	N	
Personal Hygiene	Y	N	

CURRENT MEDICINAL USE :

....

....

....

....

....

....

....

....

....

....

....

....

How Long have you been treating the Patient?		
GENERAL NOTES:		
MEDICAL PRACTITIONER's NAME:		
ADDRESS:		
DR. SIGNATURE	**DATE**	
	TEL	