JOHANNESBURG CORONATION FOUNDATION (NPO 000-726)
"QUEENSHAVEN"

MEDICAL REPORT

To be completed by your Doctor.

FULL NAMES:

....

AGE: .... SEX: .... MARITAL STATUS: ....

MEDICAL AID NAME AND PLAN:

....

MEMBERSHIP NUMBER:

....

HOW LONG HAS THIS APPLICANT BEEN A PATIENT OF YOURS?

....

RECENT ILLNESSES, OPERATIONS AND INJURIES WITH DATES:

....

....

....

....

PRESENT DIAGNOSIS:

....

....

....

CHRONIC CONDITIONS: ....

....

....

MEDICATION:

ALLERGIES...

....

HABITS: Tobacco √ [ ] Alcohol √ [ ] Drugs √ [ ] Laxatives √ [ ]

....

BLOOD PRESSURE:..

URINE TEST:...

SPECIAL DIET:..

....

Is the patient continent of -

a) BLADDER [Y] [N]

b) BOWEL [Y] [N]

WEIGHT: ....Recent Loss ....

Recent gain ....

Indicate where assistance is needed with the following –

a) Walk .... [Y] [N]

b) Dress .... [Y] [N]

c) Eat .... [Y] [N]

d) Get into and out of a bath .... [Y] [N]

e) Get on and off the toilet .... [Y] [N]

f) Communicate .... [Y] [N]

g) Handle personal affairs .... [Y] [N]

GENERAL APPEARANCE:

....

....

MENTAL STATE (memory, emotional, alert, disorientated):

....

....

DOES THE PATIENT USE - a) walker .... Y N

b) walking stick .... Y N

c) wheelchair .... Y N

IS THE PATIENT HYDRATED? Y N

....

DOES THE PATIENT USE HEARING AIDS, SPECTACLES – PROSTHETIC AIDS? Y N

If yes, please specify ………..................

....

....

ARE YOU AWARE IF THIS PATIENT IS HIV POSITIVE? Y N

IF YES, DO YOU HAVE MEDICAL REPORTS TO SUBSTANTIATE THE ABOVE? Y N

FULL NAME OF DOCTOR: ....

ADDRESS: ....

....

....

PRACTICE NO…………………………………………….. TELEPHONE NO. ....

SIGNATURE: .... DATE: ....

STAMP: ....

For office use: