Communicare

MEDICAL CERTIFICATE

(IN RESPECT OF AN APPLICANT SEEKING ADMISSION TO A COMMUNICARE RETIREMENT COMPLEX)

NOTE TO : (1) APPLICANT
This certificate must be completed by a Medical Practitioner who has been attending to you for **longer than one year**.

(2) MEDICAL PRACTITIONER
Please complete the form in detail

NB : Replies to all questions are required to facilitate evaluation of Applicant and administrative arrangements.

---

1. Name of Applicant : _____

   Date of Birth : _____

2. Applicant's medical history, symptoms and previous treatment: (State Hospital where treated and hospital reference number please)

   _____

   _____

   _____

   _____

   ReferenceNumber : _____

3. General Examinations:

   3.1 General physical and nutritional state : _____

   _____

   3.2 Respiratory System:

   3.2.1 Cardio-vascular system : _____

   3.2.2 Blood pressure (must be taken in all cases) : _____

   3.3 Alimentary and other abdominal systems : _____

   _____

   _____

   3.4 Musculo-skeletal system (state divergence) : _____

   _____

   3.5 Central nervous system (in Epilepsy particularly, state type, severity, frequency of attacks and extent of mental deterioration if any, and response to treatment)

   _____

   _____

   3.6 Any other disabling condition not included in the above classification? : _____

   _____

   3.7 Has the applicant a communicable disease? (eg. VD, TB) : _____

   _____

Communicare

3.8 Is the applicant's vision satisfactory? Does the applicant suffer from incipient or established blindness?

3.9 Is the applicant a suspect or proven case of Tuberculosis? If yes, is applicant on medication?

3.10 Is there any suspicion of neoplasm?

4. Has the applicant any history of alcohol or drug dependence?

If so, please provide detail :

5. Does the applicant require regular assistance in respect of mobility and dressing or undressing? :

6. What is the applicant's mental condition? (Please tick applicable term(s):

6.1 Normal ☐ Depressive ☐ Senile Dementia ☐

Difficult to control and/or aggressive ☐ Psychotic/mania depression ☐

6.2 Does the applicant have reasonable recall of recent events?

If not, please comment :

6.3 Is applicant fully time and place orientated?

If so, please comment :

6.4 Has he applicant any history of wandering from home?

If so, please detail :

6.5 Has the applicant any history of psychiatric treatment?

If so, please comment when and the severity of the condition :

7. Does the applicant suffer from Parkinsonism?

Communicare

8. Does the applicant suffer from:

8.1	Rheumatism / Multiple sclerosis / Muscular dystrophy	☐
8.2	Non-painful chronic Osteo-arthritis	☐
8.3	"Burnt-out" type of Rheumatiod arthritis	☐
8.4	Tabes dorsails and other locomotive disabilities	☐
8.5	Old hemiplegia or amputations	☐
8.6	Cancer	☐
8.7	Heart diseases	☐

9. Can applicant live independently at present? _____

If yes, which of the following does he/she manage to do independently?

9.1	Cooking	☐
9.2	Housekeeping	☐
9.3	Shopping	☐
9.4	Bathing	☐
9.5	Climbing steps	☐
9.6	Use public transport	☐

10. How long have you been in attendance to applicant? _____

11. Is applicant's mental/physical condition controlled by drugs? _____

If yes, please indicate which drugs and what signs are to be watched for in respect of re-evaluation : _____

_____

_____

_____

12. General Remarks : _____

_____

_____

_____

_____

_____ _____

MEDICAL PRACTITIONER / DISTRICT SURGEON DATE

ADDRESS : _____

_____

TELEPHONE NO. (B) _____ (H) _____