



MEDICAL CERTIFICATE IN RESPECT OF AN APPLICANT SEEKING ADMISSION TO HOMES FOR THE AGED
OR ANNUAL MEDICAL REQUIRED FOR ALL RESIDENTS
(To be completed by a Medical Practitioner or District Surgeon)

N.B.: Replies to all questions are required to facilitate nursing and administrative arrangements.

1. SURNAME OF APPLICANT\RESIDENT _____ FIRST NAME(S): _____
(In Block Letters)
2. APPLICANT\RESIDENT'S COMPLAINTS (HISTORY, SYMPTOMS & PREVIOUS TREATMENT - STATE HOSPITAL WHERE TREATED):
(Please Print)
Medical: _____
Surgical: _____
Psychiatric: _____
3. GENERAL EXAMINATIONS:
 - a) General physical and nutritional state _____ Temp: _____
 - i) Weight/Mass: _____ ii) Appetite: _____
 - b) Respiratory system _____
 - c) Cardio-vascular system _____ Pulse: _____
Hb: _____ B/P: _____
 - d) Genito-urinary system _____
Dysuria: _____ Urine test results: _____
 - e) i) Gastro-intestinal system _____
ii) Hernia _____
 - f) Muscular-skeletal system: Does the applicant suffer from? (Please delete terms not applicable)
 - i) Osteoporosis _____
 - ii) Osteoarthritis _____
 - iii) Rheumatoid arthritis _____
 - iv) Locomotive disabilities _____
 - v) Hemiplegia _____
 - vi) Myopathies _____
 - g) 1. Central nervous system _____
 - 1.1 Tremors _____
 - 1.2 Parkinson's _____ Multiple Sclerosis: _____ Motor Neurone: _____2. Neuropsychiatric _____ Other: _____
 - h) Endocrine system _____ HGT: _____
 - i) Ear, nose and throat _____
 - j) Eyes _____
 - i) Vision levels _____
 - ii) Spectacles / contact lenses / implants _____
 - k) Does the applicant\Resident suffer from any disease of the skin? (Include bedsores, ulcers, etc.) _____

4. a) Degree of mobility _____
b) Is the applicant incontinent? Type: _____ Urine: _____ Faeces: _____

- c) i) Has the applicant/resident any communicable disease? (e.g. TB)
ii) Current treatment _____
- d) i) Presence or suspicion of neoplasm, tumours? _____
ii) Treatment regime? _____
- e) Has the applicant/resident any known allergies or sensitivities? (If so, please detail) _____
- f) Has the applicant/resident any history of alcohol or drug dependency? (If so, please detail) _____ Smoker: Y / N
- g) Dentition: _____ Caries: _____ Dentures: _____
- h) i) Is the applicant/resident's hearing: GOOD _____ PARTIALLY DEAF _____ DEAF _____ (Please tick appropriate box)
ii) Hearing aid use: Yes / No
- i) Does the applicant/resident require:
i) Regular assistance in respect of mobility, personal hygiene, medication and dressing or undressing? _____
ii) Constant and prolonged assistance regarding mobility, dressing or undressing, feeding and personal hygiene? _____
- j) What is the applicant/resident's mental condition? _____ Mini-mental test result _____
(Please tick if one or more are applicable)
a) i) Normal _____ iv) Restlessness _____
ii) Depression _____ v) Insomnia _____
iii) Senile Dementia _____ vi) Anxiety _____
iv) Abusive and/or aggressive/violent _____
v) Behaviour Disorder _____
vi) Psychosis _____
- b) i) Does the applicant/resident have reasonable recall of recent events? _____
ii) Is applicant/resident fully time-and-place orientated? _____
iii) Has the applicant/resident any history of wandering from home? _____

5. HOW LONG HAVE YOU BEEN IN ATTENDANCE ON APPLICANT/RESIDENT? (IF FIRST VISIT, NAME OF USUAL MEDICAL DOCTOR, DAY HOSPITAL CARD NUMBER IF APPLICABLE):

6. FURNISH DETAILS OF ALL CURRENT MEDICATION: _____

i) Please indicate signs to be watched for in respect of re-evaluation _____

ii) Follow-up dates for tests, surgery, and repeat prescriptions _____

7. GENERAL REMARKS: _____

Place: _____ Date: _____

Signed: _____ General Practitioner/District Surgeon