Medical Certificate

Part 1

1. Name of Application:_____ Age: _____
2. Applicant's complaints (history, symptoms, previous treatment):

   _____

   _____

3. General Examination
   a. General physical and nutritional state:_____
   b. Respiratory system:_____
   c. Cardiovascular system:_____
   d. Blood pressure (must be taken):_____
   e. Genitourinary system (urine must be tested):

      _____

   f. Alimentary and abdominal system:

      _____

   g. Muscular-skeletal system (state divergence):

      _____

   h. (i.) Central nervous system (in epilepsy, particularly state type, severity, frequency of attacks and extent of mental deterioration, if any, and response to treatment:

      _____

      _____

      (ii.) Mental condition (in mental cases, including deficiency, particularly state type and mental age, if possible, and if institutional care is advisable:

      _____

      _____

   i. Any other disabling condition not included in above classification:

      _____

      _____

4.

a. Is the applicant bedridden? Y / N
b. Is the applicant incontinent? Y / N
c. Can the applicant be satisfactorily cared for by an unskilled attendant?

_____

d. Is the applicant free from a communicable disease? Y / N
e. Is the applicant capable of carrying out light duties? Y / N
f. Is the applicant capable of feeding and dressing themself? Y / N

5. Will the applicant benefit from further medical and hospital treatment? If so, please provide details:

_____

_____

6. General remarks:

_____

_____

Part 2

1. Can the application walk without assistance: _____

(a.) Crutches (b.) Wheelchair

2. Are they able to attend to themself in the bathroom or lavatory? Y / N
3. Is their vision satisfactory? Y / N
4. Have they got a hernia? Y / N
   If so, is it controllable by truss? Y / N
5. Is the applicant a suspected or proven case of tuberculosis?

_____

6. Is there any suspicion of neoplasm? _____
7. What is the applicant's current mental condition (cross out not applicable):
   (a.) Normal (b.) Senile (c.) Difficult to control (d.) Psychotic

8. Do they suffer from a disease of the skin: _____
9. Do they suffer from Parkinson's disease? (*Please note: a complete attached medical history is required if so*) Y / N
10. Do they suffer from the following:
    a. Rheumatism: Y / N
    b. Non-painful chronic osteoarthritis: Y / N
    c. "Burnout" type rheumatoid arthritis: Y / N
    d. Tabes dorsalis or other locomotive disabilities: Y / N
    e. Old hemiplegia: Y / N
    f. Old cerebral atrophies and hemiplegics: Y / N
    g. Myopathies: Y / N
11. How long have you know and treated the applicant:_____

Place: _____ **Date:** _____

Medical Practitioner:

Full Name in block letters: _____

Telephone Number: _____

N.B. Please note, this applicant will be re-examined on admission to the home