ALGOA BAY COUNCIL FOR THE AGED

MEDICAL REPORT

*This form to be completed by a **practising Doctor** or **clinic sister***

Applicants Name: _____

Applicant's general state of health is: _____

Applicant's mental state is: _____

Is applicant on psychiatric medication?: Yes ☐ No ☐

State conditions of the following:

Hearing: _____ **Eyesight:** _____

Heart: _____ **Blood Pressure:** _____

Lungs: _____ **Kidneys:** _____

Skeleton: _____ **Muscles:** _____

Skin: _____ **Abdomen:** _____

Digestion: _____ **Memory:** _____

Bladder Control: _____ **Bowel Control:** _____

State any particular ailments:

_____

_____

_____

Does applicant suffer from epilepsy?: Yes ☐ No ☐

Does applicant have any contagious or infectious diseases?: Yes ☐ No ☐

Can applicant perform the following without assistance?:

Eating: Yes ☐ No ☐ **Dressing:** Yes ☐ No ☐

Bathing: Yes ☐ No ☐ **Walking:** Yes ☐ No ☐

General comments in support of application:

_____

_____

_____

_____

_____ _____

Signed **Date**

_____

Doctor or Clinic Sister's Name

Address: _____

_____

_____

_____

Postal Code: _____

Official Stamp