ZILISIMENYE ELDERLY HOME

Reg: 165-756NPO

MEDICAL REPORT FORM:

Personal details of the patient:

SURNAME	
FIRST NAMES	
DATE OF BIRTH	
AGE	
GENDER	

1. Medical History (major illnesses, including birth and family history if known)

2. PHYSICAL EXAMINATION

2.1. General Appearance

2.2. Skin

2.3. Mouth and Teeth

2.4. Respiratory System (Also indicate any previous history of TB)

2.5. Cardiovascular System

2.6. Gastro-intestinal Tract

2.7. Genitourinary

2.8. Muscular- Skeletal (Especially deformities)

2.9. Gait

2.9. Central Nervous System

2.10. Behavioural problems

3. DIAGNOSIS / ASSESMENT

- Neuro –Cerebral
- C.V.A. – How long ago?
- Previous Neuro surgery YES NO
- V.P. Shunt YES NO
- Aggression YES NO
- Depression YES NO
- Epilepsy YES NO
- Other (please specify)

4. **Present Treatment and Related information:**

5. **Information recommendation on continued care at receiving NGO:**

6. **Feeding:**

Normal diet: YES NO

Special Diet: YES NO

Teeth: YES NO

Dentures: YES NO

Tube Feeding:

Reason for Tube Feeding?

Is the tube fed permanent YES NO

i.	Naso – gastric feeding	YES	NO
ii.	Gastro intestinal tube	YES	NO
iii.	Constipation	YES	NO
iv.	Colostomy	YES	NO
v.	Incontinent	YES	NO
vi.	Catheter	YES	NO
vii.	Allergies	YES	NO
viii.	Diabetic	YES	NO

6.1. Allergies YES or NO

If yes please specify

6.2. Drug/ alcohol addiction YES or NO

If yes please specify the number of years of Drug or Alcohol abuse or substance abuse:

Details of GP/ Medical Practitioner:

Designation:

Name:

Signature:

Date:

ZILISIMENYE ELDERLY HOME

REG: 165-756NPO

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Vereeniging,
1939

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SOCIAL WORKER REPORT

1. Background History

2. Housing

3. Contributing factors that led to the application for admission:

— If neglect/abuse is the reason for application:

— What steps have been taken:

— Prevention or Legal steps have been taken:

4. Any disorders YES ☐ NO ☐
If YES, specify the psychiatric clinic or treatment centre

5. Any drug/alcohol dependency history YES ☐ NO ☐
IF YES, please specify previous treatment of the Centre/ Clinic.

6. General Mental Condition

Mainly Clear	YES	☐	NO	☐
Forgetful	YES	☐	NO	☐
Disinterest	YES	☐	NO	☐
Suicidal Tendencies	YES	☐	NO	☐

IF YES, specify treatment and centre.

7. Social Contact

Family
Church
Community

8. Financial Circumstances

9. Alternative Care

Community Based Care YES ☐ NO ☐
If yes please specify

Meals on Wheels YES ☐ NO ☐

Home Based Nursing Care YES ☐ NO ☐

Other Homes/ Centres

Social Worker Signature .....

Print Name .....

Telephone No: .....

Date: .....