SIR MOSES MONTEFIORE JEWISH HOME
MEDICAL EVALUATION FORM

1. This form needs to be completed by the prospective resident's Medical Officer.
2. APPLICATION FORM AND MEDICAL FORM SHOULD BE RETURNED TOGETHER.
3. Every application is assessed on this report and an interview.
4. Please fill in details as comprehensively as possible.
5. Lack of information may cause delay in assessment.

SURNAME: _____ **GIVEN NAMES:** _____

Current Address:_____

_____Phone: _____

Medicare No: _____ Pharmaceutical No: _____

Pension no: _____ Health Insurance Fund: _____

Date of Birth: _____ Country of Birth: _____

Marital Status: _____

PERSON RESPONSIBLE TO CONTACT IN EMERGENCY:

Name: _____ Relationship: _____

Address: _____

_____

Phone (Private): _____ Phone (Mobile): _____

Reason for seeking admission: _____

NAME AND ADDRESS OF DOCTOR COMPLETING FORM: _____

_____

_____ Phone: _____

Length of time he/she has known applicant: _____

Is applicant presently at: Home ☐ Hospital ☐ Nursing Home ☐ Other Accommodation ☐

ALLERGIES _____

Blood pressure:_____ Pulse:_____

BSL:_____ Weight: _____Height: _____

SYSTEMS REVIEW

- ***EXAMPLE***

DIAGNOSES	***MEDICATION LINKED***	***RELATED PROCEDURE***
Arthritis	*Panadol*	*Heat Packs*

- **CARDIOVASCULAR**

DIAGNOSES	***MEDICATION LINKED***	***RELATED PROCEDURE***
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

- **RESPIRATORY**

DIAGNOSES	***MEDICATION LINKED***	***RELATED PROCEDURE***
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

- **CENTRAL NERVOUS SYSTEM**

DIAGNOSES	***MEDICATION LINKED***	***RELATED PROCEDURE***
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

- **GASTROINTESTINAL**

DIAGNOSES	***MEDICATION LINKED***	***RELATED PROCEDURE***
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

- **ENDOCRINE**

DIAGNOSES	***MEDICATION LINKED***	***RELATED PROCEDURE***
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

- **HAEMOPOETIC**

DIAGNOSES	***MEDICATION LINKED***	***RELATED PROCEDURE***
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

- **SKIN DISEASE**

DIAGNOSES	***MEDICATION LINKED***	***RELATED PROCEDURE***
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

- **GENITOURINARY**

DIAGNOSES	***MEDICATION LINKED***	***RELATED PROCEDURE***
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

- **MUSCULOSKELETAL**

DIAGNOSES	***MEDICATION LINKED***	***RELATED PROCEDURE***
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Does the patient have a diagnosis of dementia: ☐ Yes ☐ No

If yes, which type:

☐ Alzheimer's	☐ Vascular	☐ Lewy Body	☐ Picks
☐ Undifferentiated	☐ Mixed	☐ Uncertain	☐ Other

In the case of a diagnosis of dementia, the patient will require a valid (done within 6 months) report from a psychogeriatrician.

Does the patient have symptoms of depression: ☐ Yes ☐ No

Further information: _____

_____

_____

_____

_____

Assistance with Mobility

Independent	☐ Yes	☐ No
Supervision with walking	☐ Yes	☐ No
Mechanical Aid (frame, wheelchair, stick etc)	☐ Yes	☐ No
Hearing Aids	☐ Yes	☐ No
Glasses	☐ Yes	☐ No

Continence

Continent of urine	☐ Yes	☐ No
Continent of faeces	☐ Yes	☐ No

Signed: _____ **Date**: _____
(Medical Practitioner)