Maroubra Shores
RESIDENTIAL CARE
MANAGED BY MONTEFIORE

MEDICAL EVALUATION FORM

1. This form needs to be completed by the prospective consumer'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 (Home):	Phone (Mobile):
Reason for seeking admission:	

NAME AND ADDRESS OF DOCTOR COMPLETING FORM:	
Name:	
Address:	
	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 applicant 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 applicant will require a valid (done within 6 months) report from a psychogeriatrician.

Does the applicant 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)