Elderly Services

Medical Report *(To be filled by a Doctor as applicable)*

1. Medical History & Diagnosis

2. Communication Abilities

3. Psychological State

☐ Fully Oriented ☐ Occasionally Confused ☐ Confused ☐ Disoriented

4. Behavioural State

☐ Good ☐ Apathetic ☐ Aggressive ☐ Wandering

5. ADLs (Activities of Daily Living)

	Independent	Assisted	Dependent
Feeding	☐	☐	☐
Grooming	☐	☐	☐
Dressing	☐	☐	☐
Bathing	☐	☐	☐
Toileting	☐	☐	☐
Mobility	☐	☐	☐

6. List of Medications

7. Social Situation

The applicant: ☐ Lives Alone ☐ Lives with Someone Else ☐ Sapport Social Network

8. Domiciliary Allied Health Intervention

Applicable only for the frail, vulnerable and those who cannot exit own homes. ☐ Yes ☐ No

9. For Continence Service kindly indicate a valid clinical reason. If pull ups are being requested specify reason why pull ups and not another product _____

_____

10. Other Relevant Information *(include other clinics / services used)*

_____ _____ _____

Name & Surname *(Doctor)* Medical Council Number Signature *(Doctor)*

_____ _____

Contact No. *(Doctor)* Date

Rubber Stamp