HOMES FOR SPECIAL CARE

To be completed by physician

MEDICAL REPORT & DISCHARGE SUMMARY **Name:**________________________________

A. **Diagnosis (Primary)**____

B. **Diagnosis (Secondary)** ____

C. **Intercurrent Conditions**____

FUNCTIONAL DISABILITIES: **(Indicate item and explain below)**

a.	**Sight**	**Good** ☐	**Partial** ☐	**Glasses** ☐	**Blind** ☐
b.	**Hearing**	**Good** ☐	**Partial** ☐	**H. Aid** ☐	**Deaf** ☐
c.	**Teeth**	**Good** ☐	**Defective** ☐	**Dentures** ☐	**None** ☐

SYSTEMIC CONDITIONS: **(Indicate applicable item and specify below)**

Seizures ☐	**Dysphagia** ☐	**Dysarthria** ☐	**Aphasia** ☐	**Dysuria** ☐
Haemorrhoids ☐	**Polyuria** ☐	**Diabetes** ☐	**Dyspnoea** ☐	**Hernia** ☐
Cardiac Failure ☐	**Emphysema** ☐	**Arthritis** ☐	**Neurological Deficit** ☐	
Allergies ☐				

REMARKS:____

____

Blood Pressure: _________________**Last Physical Exam by Dr.**__________________________**Date**_____________

Radiology **(Chest)** ____

Urinalysis Sp. Gr._______**React**_______**Alb.**___________**Sug/Act**_____________**Micro**________________________

Haematology Hgb. ______________**W.B.C.**___________**VDRL**___________….__________….___________

Dental Treatment

Fillings_______________ **Extractions**_____________________ **Date**_________________________________

Peridontal ____

Prothesis Provided ______________________________ **Dentist**___________________________________

Regular Medication	**Dose & Frequency**	**Date Started**

CARE RECOMMENDED: **Nursing** ☐ **Residential** ☐ **Drug Reaction Alert** ☐

Special Suggestions: ____

______________________________________ ______________________________________

Signature Staff Physician **Name & Telephone Number**

Date____