(Revised 11/2024)

**RESTRICTED**

##### Day/Residential Care Service for Intellectually or Physically Disabled Persons

##### Medical Examination Form

## **Personal Data of Applicant**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: (English) |  | (Chinese) |  |
| Sex/Age/D.O.B.: |  | HKIC No.: |  | Tel.: |  |

## **Major Diagnosis**

|  |  |
| --- | --- |
| Intellectual Disability | [ ]  Mild [ ]  Moderate [ ]  Severe [ ]  Profound |
| Physically Disability | Please specify: |  |
| Psychiatric Illness | Diagnosis: |  |
|  | Follow-up Interval: |  |

## **Medical History**

|  |  |  |  |
| --- | --- | --- | --- |
|  | No | Yes | If yes, please elaborate: |
| Symptoms of Infectious Diseases e.g. diarrhea, rash, frequent cough, past chest infection, etc. | [ ]  | [ ]  |  |
|  |
| Allergy to Food or Drug | [ ]  | [ ]  |  |
| Epilepsy | [ ]  | [ ]  | mild (once a month) |  |
|  |  | [ ]  | moderate (once a week) |  |
|  |  | [ ]  | severe (once a day) |  |
| Swallowing Difficulties/Easy Choking | [ ]  | [ ]  |  |
| Recent Auditory/Visual Deterioration | [ ]  | [ ]  |  |
| Other Significant Illness | [ ]  | [ ]  |  |

|  |  |  |
| --- | --- | --- |
| Previous Operations |  | Dates |
|  |  |  |
|  |  |  |
| Current Treatment (specify dosage): |  | Name(s) of Treatment Providers (e.g. clinic): |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| Others (please specify): |  |

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## **Physical Examination**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Satisfactory | Fair | Poor |
| General Condition | [ ]  | [ ]  | [ ]  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Normal | Abnormal | If abnormal, please elaborate: |
| Skin Condition, e.g. scabies, jaundice | [ ]  | [ ]  |  |
| Lymphatic System | [ ]  | [ ]  |  |
| Dental Condition | [ ]  | [ ]  |  |
| Thyroid | [ ]  | [ ]  |  |
| Chest | [ ]  | [ ]  |  |
| Cardiovascular System | [ ]  | [ ]  |  |
| Abdomen | [ ]  | [ ]  |  |
| Limbs, Spine | [ ]  | [ ]  |  |
| Possible Signs of Infectious Diseases | [ ]  | [ ]  |  |
| Need for Special Diet | No[ ]  | Yes[ ]  | If yes, please specify: |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Body Weight: |  | kg | Blood Pressure: |  | mmHg | Pulse: |  | /min |

|  |  |
| --- | --- |
| Other Findings: |  |

|  |
| --- |
| Doctor’s Recommendations: |
| 1. | The applicant is [ ]  fit / [ ]  unfit for admission to day/residential care service.(No evidence of infectious disease or significant physical condition contraindicating placement into a group environment.) |
| 2. | The applicant should be referred to the following specialist for follow up examination: |
|  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Doctor’s Signature: |  |  | Hospital/Clinic: |  |
| Name in block letter: |  |  | Tel.: |  |
| Date: |  |  | Ref. No.: |  |

|  |  |
| --- | --- |
| *Remark:* | 1. *This medical examination form is valid for 6 months from the date of issue.*
2. *Medical examination primarily serves the purpose of formulating individual care plan rather than screening. Flexibility should be applied whenever necessary.*
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