iera VICTORIA Indochinese Elderly Refugees Association Victoria	**Indochinese Elderly Refugees Association Victoria Inc.**	**Medical Evaluation Form**

Please note: *This form needs to be completed by the prospective resident's Medical Officer. This form should accompany the application for admission form and be returned together. Every application is assessed on this report and an interview. Lack of information may cause a delay in considering your application.*

Please read carefully and tick the appropriate boxes

Details:

Last Name: _____ **First Names:** _____

Current Address: _____

_____ Phone: _____

Pension No: _____ Veterans Affairs Number:_____

Medicare Number: _____ Expiry Date: _____

Health Insurance Fund: _____ Pharmaceutical No: _____

Pension Number: _____ Marital Status: _____

Date of Birth: _____ Country of Birth: _____

Reason for Seeking Residential Care Admission: _____

Name and Address of Doctor Completing this 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		
Diagnosis	*Medication Linked*	*Related Procedure*
Arthristis	*Panadol*	*Heat Packs*
CARDIOVASCULAR		
Diagnosis	*Medication Linked*	*Related Procedure*
1.		
2.		
3.		
RESPIRATORY		
Diagnosis	*Medication Linked*	*Related Procedure*
1.		
2.		
3.		
CENTRAL NERVOUS SYSTEM		
Diagnosis	*Medication Linked*	*Related Procedure*
1.		
2.		
3.		
GASTROINTESTINAL		
Diagnosis	*Medication Linked*	*Related Procedure*
1.		
2.		
3.		
ENDOCHRINE		
Diagnosis	*Medication Linked*	*Related Procedure*
1.		
2.		
3.		
HAEMOPOETIC		
Diagnosis	*Medication Linked*	*Related Procedure*
1.		
2.		
3.		
SKIN DISEASE		
Diagnosis	*Medication Linked*	*Related Procedure*
1.		
2.		
3.		
GENITOURINARY		
Diagnosis	*Medication Linked*	*Related Procedure*
1.		
2.		
3.		
MUSCULOSKELETAL		
Diagnosis	*Medication Linked*	*Related Procedure*
1.		
2.		
3.		

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Does the patient already have any vaccinations? Yes ☐ No ☐

If yes, which type:

☐ Influenza Vaccine Date Last Given: ……

☐ Pneumococcal Vaccine Date Last Given: ……

☐ Tetanus Vaccine Date Last Given: ……..

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 the past 6 months) report from a psycho geriatrician.

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 with urine	Yes ☐	No ☐
Continent with faeces	Yes ☐	No ☐

Signed: _____ **Date**: _____

(Medical Practitioner)