PRIVATE AND CONFIDENTIAL

FLOWER FOUNDATION
Retirement Homes
Est 1963
NPO 000-836

Unit 4, Surrey Square Office Park
330 Surrey Avenue
Ferndale, 2125
P O Box 3442, Randburg, 2125
Tel: +27(0)11 781 4920
Fax: +27(0)11 781 4931
info@flower.org.za
www.flower.org.za

MEDICAL REPORT FORM

NAME.....

YEAR OF BIRTH ..... GENDER.....

ADDRESS .....

PREVIOUS MEDICAL HISTORY (please tick off relevant item/s and give years of occurrence)	
Alimentary System	
Peptic ulcer.....	Chronic dyspepsia .....
Colitis	Appendicitis .....
Cholecystitis	Other .....
Cardio-vascular System	
Coronary thrombosis	Hypertension .....
Congestive failure	Rheumatic fever .....
Anaemia.....	Peripheral vascular disease.....
Varicose veins	Other .....
Blood Pressure	
Respiratory System	
Bronchitis	Pneumonia .....
Asthma	Pneumoconiosis .....
Tuberculosis	Sinusitis .....
Emphysema	Other .....
Genito-Urinary System	
Nephritis	Renal-calculus .....
Cystitis	Prostatism .....
Stricture	Cervicitis .....
Prolapse of uterus & vaginal wall.....	Benign tumours.....
Salpingitis	Incontinency .....
Urine analysis	Other .....
Nervous System	
Cerebro-vascular accidents	Epilepsy .....
Paralysis agitans	Peripheral neuritis .....
Fainting episodes	Other .....
Metabolic	
Weight	Obesity .....
Thyroid disorders	Diabetes .....
Vitamin deficiency	Other.....
Muscular Skeletal System	
Previous injury	Osteoarthritis .....
Osteoporosis.....	Rheumatoid arthritis .....
Bone density loss %.....	Osteitis .....
Re-absorptive medication.....	Wasting or weakness.....
Risk of osteoporotic fractures / frailty fractures	Deformity due to any cause .....
Low ☐ Moderate ☐ High ☐	Other.....
Skin	
Dermatitis	Eczema .....
Tumours	Other .....

Cancer of any part of the body (list again even if listed before)	
Benign tumours of any part of the body (list again even if listed before)	
Allergies	
Sight Cataract …….. Glaucoma ……	 Vision: corrected …… Uncorrected ……
Hearing Otitis Media ……	Osteosclerosis ……

SURGICAL
List operations …… ……
List any significant accidents, giving cause, nature of injury and residual effects …… ……

MENTAL CONDITION	
List any previous psychotic episodes with dates Bipolar depressive …… Obsession …… Schizophrenic …… Psycho-neurotic ……	 Toxic psychosis …… Senile degenerative…… Reactive depression …… Shock treatment (if any) …… State where treated ……
Describe present mental condition	
Record any mental defect left as a result of congenital, traumatic, infective or other factors	
Is there any record of tobacco, drug or alcohol addiction at any time? If so, give details	

GENERAL CONDITION	
Takes care of self completely	YES/NO
Needs some help for dressing, eating	YES/NO
Chronically ill – (underline): Senile, diabetes, heart, other (please state)	YES/NO
Partially bedridden	YES/NO
Completely bedridden	YES/NO
Wheelchair case	YES/NO
Other conditions such as:	deaf ……. blind ……. other (please state) ……..

DOCTOR'S SCRIPT
PLEASE attach a valid Doctor's script (this is essential for approval of admission) ☐ *tick if attached*

GENERAL REMARKS
(Please specify any treatment for disorders)
Do you consider that physiotherapy, occupational therapy or remedial exercises will be of value to this patient?

DOCTOR'S RECOMMENDATION (Please tick one of the options below)	
INDEPENDENT LIVING *(e.g. cottage/flat, self-catering)*	☐
RESIDENTIAL LIVING *(laundry & meals provided)*	☐
ASSISTED CARE *(laundry, meals plus limited nursing assistance)*	☐
FULL CARE (*24 hour nursing care)*	☐

I HAVE EXAMINED MR/MRS/MISS …….
AND MY REPORT IS AS SET OUT ABOVE

I HAVE KNOWN THIS PATIENT SINCE ……

DATE: …….. Tel No: ……

ADDRESS: ……

DOCTORS STAMP

DOCTORS SIGNATURE ……