Medical Certificate

(To be completed by your doctor)
If a Comprehensive Medical Assessment (CAM) has been completed, please attach a copy.

Patient's Name: _____ **Date of birth:** _____/_____/_____

Current Address: _____

Postcode: _____ **Phone:** _____

Medicare Number: _____ **Health Care Fund:** _____

Current Diagnosis:

Please include both **Medical** and **Psychiatric diagnosis.**
(Please attach Specialist details including contact details and reports if available)

_____

_____

_____

_____

Past illnesses / diagnoses:

_____

_____

_____

Dementia Diagnoses: ◯ Yes ◯ No

Type of dementia: _____

Date of diagnosis (Please attach relevant reports if available): _____/_____/_____

Current Mental State:

Fully Alert and Orientated: ◯ Yes ◯ No

If ticked NO: ◯ Occasionally confused ◯ Permanently confused ◯ Likely to wander

Past operations / surgical procedures:

_____

_____

_____

_____

Smoker: ◯ Yes ◯ No **Current cigarettes / day:** _____

Alcoholic drinks / week: _____

Vaccination history:

COVID (include dose i.e. Booster 2): _____/_____/_____ **Booster:** _____/_____/_____

Flu vaccination: _____/_____/_____ **Tetanus**: _____/_____/_____

Pneumovax: _____/_____/_____

Allergies:

(e.g., drugs, food, other) (Please specify if mild, moderate or severe)

_____

_____

_____

Current medications:

(Please include all oral, topical, trans-dermal, injected, complementary medication and include strength and frequency)

_____

_____

_____

General physical:

Weight: _____ **Height**: _____ **Pulse**: _____ **BP**: _____

Dietary Requirements:

(Please specify any special dietary requirements including texture modification)

_____

_____

_____

Skin:

Condition of skin: ◯ Good ◯ Poor

Description of skin conditions / rashes:

_____

_____

_____

Wounds/bruises: ◯ Yes ◯ No

Current treatment: _____

Sleep:

Rest & Sleep pattens: ☐ Uninterrupted ☐ Interrupted (please give details)

_____

_____

_____

Sleeping medication (occasional or regular): _____

Average hours sleep/night: _____

Pain:

Painful areas of movements: (please describe)

_____

_____

Current pain management strategies:

_____

_____

Continence:

Bladder: ◯ Yes ◯ No **Bowel:** ◯ Yes ◯ No

Continence aids used (please describe):

_____

_____

Mobility (please describe, include aids used):

_____

_____

Prosthetics (dentures, hearing aids, glasses):

_____

_____

Doctors Details:

Name of Doctor (please print): _____

Signature of Doctor: _____ **Date:** _____/_____/_____

Address: _____

Phone: _____