



THE SOCIETY FOR THE PHYSICALLY DISABLED MEDICAL SUMMARY

(To be completed & signed by certified Medical Practitioner)

Name : _____

NRIC : _____ Date of Birth : _____

Sex : Male Female Date of Examination : _____

Medical Diagnosis : _____

Nature and cause of disability (state date and any operation done, if applicable):

S/No	Information Required	Please Tick YES or NO	Please specify details, if available/ applicable
1	Height : _____ cm		Weight : _____ kg
2	Has speech and hearing impairment	<input type="checkbox"/> <input type="checkbox"/>	
3	Has visual Impairment	<input type="checkbox"/> <input type="checkbox"/>	
4	Has infectious disease	<input type="checkbox"/> <input type="checkbox"/>	
5	Has HIV (lab test if necessary)	<input type="checkbox"/> <input type="checkbox"/>	
6	Has Hepatitis B (lab test if necessary)	<input type="checkbox"/> <input type="checkbox"/>	
7	Has history of Heart Disease (If applicable, please state the precautionary measures)	<input type="checkbox"/> <input type="checkbox"/> Blood Pressure: _____	
8	Has history of Lungs Disease (If applicable, please state the precautionary measures)	<input type="checkbox"/> <input type="checkbox"/>	
9	Has problems with Bladder and Bowl Function	<input type="checkbox"/> <input type="checkbox"/>	
10	Has Diabetic Conditions	<input type="checkbox"/> <input type="checkbox"/>	

S/No	Information Required	Please Tick <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		Please specify details, if available/ applicable
11	Has history of epileptic episodes, paralysis, seizure or other abnormality of the central nervous system.	<input type="checkbox"/>	<input type="checkbox"/>	
12	Has history of Mental illness e.g. depression / schizophrenia / bipolar disorders etc (If applicable)	<input type="checkbox"/>	<input type="checkbox"/>	
13	Has history of aggressive and violent behaviour	<input type="checkbox"/>	<input type="checkbox"/>	
14	Has allergy to drugs, food, etc?	<input type="checkbox"/>	<input type="checkbox"/>	
15	Is currently on medication (If Yes, please specify)	<input type="checkbox"/>	<input type="checkbox"/>	
16	Requires special diet	<input type="checkbox"/>	<input type="checkbox"/>	
17	Therapy History (Please attach Physiotherapy / Occupational Therapy / Speech Therapy Reports if available). _____ _____			
18	Other comments/observations: _____ _____			

_____ is fit / unfit for participation in the
 (Name of Client/Applicant)
 Rehabilitation Services / Day Activity Centre / Vocational Training Programmes.

Signature and Name of Examining Medical Practitioner

Date

Name and address of Clinic : _____

Contact No : _____