**GENEESKUNDIGE VERSLAG VIR OPNAME**

**MEDICAL REPORT FOR ADMISSION**

**1. Van/Surname:** …………………….........................................................................................................

**2. Volle name/Full names:** ………………………………………………………………………………………

**3. Geboortedatum/Date of Birth:** ………………………….. **4. Ouderdom/Age:** ……………………..

**5. APPLIKANT SE MEDIESE GESKIEDENIS INSLUITEND VORIGE BEHANDELING EN CHIRURGIE:**

**DETAILS OF APPLICANT’S MEDICAL HISTORY, PREVIOUS TREATMENT AND OPERARTIONS:**

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**6. ALLERGIEË/ALLERGIES:**

**6.1 Voedsel / Food (bevestig met Dr sertifikaat / Confirm with Dr certificate).**

**6.2 Medikasie / Medicine (bevestig met Dr sertifikaat / Confirm with Dr ceretificate).**

**7. ALGEMENE ONDERSOEK / GENERAL EXAMINATION:**

1. **Enige spesiale dieet verlang (bevestig met Dr sertifikaat) / Any special diet requirements (confirm with Dr certificate):**

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1. **ASEMHALINGSTELSEL / RESPIRATORY SYSTEM:**

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**Naam van Applikant / Name of applicant:** ………………………………………………………………….

1. **KARDIOVASKULÊRE SISTEEM / CARDIO VASCULAR SYSTEM:** ………………………………….

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1. **BLOEDDRUK LESING / BLOOD PRESSURE READING:** …………………………………………….
2. **IS DIE APPLIKANT ‘N DIABEET (MELD ASSEBLIEF TIPE) / DOES THE APPLICANT SUFFER FROM DIABETES (NAME TYPE PLEASE):**

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1. **GESLAGORGANE EN URIENSTELSEL** (Urine moet asseblief in alle gevalle getoets word):

**UROGENITAL SYSTEM** (Every applicant’s urine to be tested):

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1. **SPYSVERTERING EN ANDER ABDOMINALE PROBLEME** (Noem asseblief) **/ ANY DIGESTIVE AND OTHER ABDOMINAL PROBLEMS (**Please specify):

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1. **SPIER EN SKELETSTEL** (Spesifiseer asseblief) **/ MUSCULAR AND SKELETAL SYSTEM** (Specify please):

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1. **SENTRALE SENUWEESTELSEL (**In geval van epilepsie, meld asseblief tipe enbehandeling opmedikasie) **/ CENTRAL NERVOUS SYSTEM (**In the event of epilepsy please specify reaction to medication):

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1. **GEESTESTOESTAND** (Ly die applikant aan van die volgende?) **/ MENTAL CONDITION** (Doesthe applicant suffer from any of the following?):

* **DEPRESSIE/DEPRESSION:** …………………………………………………………………………..
* **SENIELE DEMENSIE / SENILE DIMENTIA** (Spesifiseer asseblief / Please specify):

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* **AGRESSIEWE GEDRAG / AGRESSIVE BEHAVIOUR:** ……………………………………………

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* **PSIGOSE en/of NEUROSE / PSYCHOSIS and/or NEUROSIS:** …………………………………..

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**INDIEN VAN TOEPASSING, BESKRYF ASSEBLIEF BOGENOEMDE GEVAL EN MELD OF APPLIKANT VIR GENOEMDE PROBLEEM TOEGELAAT WAS IN ‘N NEUROKLINIEK / IF APPLICABLE, DESCRIBE ABOVE MENTIONED INCLUDING ANY PREVIOUS SUBMISSION TO A NEURO CLINIC: (\*)**

**Naam van applicant / Name of applicant:** ……………………………………………………………..

**(\*)** ……………………………………………………………………………………………………………..

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1. **Is die applikant VRY van OORDRAAGBARE en AANSTEEKLIKE SIEKTES?** (bv. TB, Geslagsiektes ens) **/ Does the applicant have any INFECTIOUS or CONTAGIOUS DISEASES** (eg. TB, Sexually transmittes disease, etc?):

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1. **Het die applicant problem met? / Does the applicant suffer from?:**

**(i) DOOFHEID/LOSS OF HEARING:** …………………………………………………………………….

**(ii) SWAK SIG/POOR VISION:** …………………………………………………………………………….

1. **HET DIE APPLIKANT 'N VORIGE GESKIEDENIS VAN KANKER? (INDIEN JA BESKRYF ASSBLIEF) / DOES THE APPLICANT HAVE A HISTORY OF CANCER ? (IF YES, PLEASE SPECIFY):**

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1. **HET DIE APPLIKANT ‘N GESKIEDENIS VAN ALKOHOL/DWELMMISBRUIK? (INDIEN JA BESKRYF ASSEBLIEF) / DOES THE APPLICANT HAVE A HISTORY OF ALCOHOL/DRUG ABUSE? (IF YES, PLEASSE SPECIFY):**

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1. **ENIGE ANDER TOESTAND BUITEN BOGEMELDE? / ARE THERE ANY OTHER SIMILAR CONDTIONS NOT MENTIONED ABOVE?:**

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**8. Is die APPLIKANT / Is the APPLICANT:**

**(1). Permanent bedlêend / Permanently Bedridden?:** …………………………………………………….

**(2). Rolstoel gebeonde / In a wheelcahair?:** ………………………………………………………………..

**9. Kan die applikant bevredigend deur ‘n ONOPGELEIDE OPPASSER versorg word?**

**Can the applicant satisfactorily be cared for by an UNQUALIFIED CAREGIVER?**

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**Naam van applikant/Name of applicant:** ……………………………………………………………………………

**10. Is applikant ONBEHEERBAAR / What is the applicant’s MENTAL EQUITY?**

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**11. HET APPLIKANT GEREELDE HULP NODIG MET MOBILITEIT ? (BV ROLSTOEL, ROLATOR, KRUKKE, KIERIE ENS) / DOES THE APPLICANT REQUIRE ASSISTANCE WITH MOBILITY? (EG. WHEELCHAIR, ROLATOR CRUTCHES,WALKING STICK ETC):**

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**12. Het die applikant KORTTERMYN of LANGTERMYN HULP nodig ivm VOEDING en PERSOONLIKE HIGIËNE / Does the applicant REQUIRE SHORT TERM or LONG TERM ASSISTANCE with FEEDING and PESONAL HIGIENE?:**

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**13. SAL VERDERE GENEESKUNDIGE/CHIRURGIESE BEHANDELING DIE GEBREKE HIERBO BESKRYF, VERBETER OF GENEES? (INDIEN WEL, VERDUIDELIK ASSEBLIEF WATTER BEHANDELING AANBEVEEL WORD / DOES THE APPLICANT REQUIRE ANY SURGERY OR FURTHER TREATMENT WHICH WILL IMPROVE THEIR PRESENT CIRCUMSTANCES OR RESTORE THEIR HEALTH? (IF YES, PLEASE SPECIFY THE TREATMENT SUGGESTED).**

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**14. MELD ASSEBLIEF HOE LANK U DIE APPLIKANT AS U PASIENT BEHANDEL / KINDLY INDICATE THE PERIOD YOU ARE TREATING THE APPLICANT AS YOUR PATIENT:**

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**15. KRONIESE MEDIKASIE IN GEBRUIK (VERSKAF ASSEBLIEF ‘N AFSKRIF VAN DIE VOORSKRIF) CHRONIC MEDICATION IN USE (KINDLY PROVIDE A COPY OF THE PRESCRIPTION):**

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**16. ALGEMENE OPMERKINGS / GENERAL REMARKS:** ……………………………………………………...

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**Naam en van, van geneesheer asook praktyknommer (in drukskrif) / Doctor’s name and surname as well as practice number (blocletters):**

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**Adres/Address:** ………………………………………………………………………………………………………...

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**Telefoonnommer/s / Telephone number/s :** …………………………………………………………………........

**Handtekening: Geneesheer / Signature: Doctor:** …………………………………………………………………

**Datum/Date:** …………………………………………………………………………………………………………….

**Amptelike stempel/Official stamp**