STRICTLY PRIVATE & CONFIDENTIAL

MEDICAL CERTIFICATE IN RESPECT OF A LIFE RIGHT PURCHASE

(To be completed by a Medical Practitioner or District Surgeon)

Replies to all questions are required to facilitate nursing and administrative arrangements.

1. **SURNAME** _____ **FIRST NAMES** _____ **AGE** _____

2. **MEDICAL HISTORY** (complaints, symptoms, previous treatment, name hospital/institution)
   Medical: _____
   Surgical: _____
   Psychiatric: _____

3. **GENERAL EXAMINATIONS**
   a. General physical & nutritional state _____ Temp: _____
   b. Weight/mass: _____ Appetite: _____
   c. Respiratory system: _____
   d. Cardio-vascular system: _____ Pulse: _____
   e. Hb: _____ B/P: _____
   f. Genito urinary system: _____
      i. Dysuria _____ Urine test results: _____
   g. Gastro-intestinal system: _____
   h. Hernia: _____
   i. Musculo-skeletal system: Does the individual suffer from :-
      i. Osteoporosis _____
      ii. Osteoarthritis _____
      iii. Rheumatoid arthritis _____
      iv. Locomotive disabilities _____
      v. Hemiplegia _____
      vi. Myopathies _____

j. Central nervous system:
   i. Tremors_____
   ii. Parkinson's_____
   iii. Multiple Sclerosis_____
   iv. Motor neurone_____
   v. Neuropsychiatric_____
   vi. Other_____
k. Endocrine system:_____ HGT:_____
l. Ear, nose & throat:_____
m. Eyes:_____
   i. Vision levels_____
   ii. Spectacles/ contact lenses/ implants_____
n. Skin diseases (includes bed sores, ulcers etc.)_____

4. **DEGREE OF MOBILITY**_____
   a. Is the applicant incontinent? Type:_____ Urine:_____ Faeces:_____
   b. Has the applicant any communicable diseases (e.g. TB)?_____
      i. Disease:_____
      ii. Current treatment:_____
   c. Presence or suspicion of neoplasm, tumour?_____
   d. Known allergies or sensitivities (please detail):_____
   e. History of drug or alcohol dependence (please detail):_____
   f. Definition:_____ Caries:_____Dentures:_____
   g. State of individuals hearing (please detail):
      i. Hearing aid use?_____
   h. Does the individual require?
      i. Regular assistance with mobility, personal hygiene, medication, dressing or undressing and bathing / showering?_____
      ii. Constant and prolonged assistance with the above:_____
   i. What is the individuals mental condition?_____ Mini-mental test result:_____
      i. Normal_____
      ii. Restless_____
      iii. Depression_____
      iv. Insomnia_____
      v. Senile dementia_____
      vi. Abusive and/or aggressive_____
      vii. Behaviour disorder_____
      viii. Psychosis_____

ix. Memory/recall of events_____

x. Time and space orientation_____

xi. History of wandering from home_____

5. **HOW LONG HAVE YOU BEEN IN ATTENDANCE OF THIS INDIVIDUAL?** (If first visit name of family doctor):_____

6. **FURNISH DETAILS OF ALL CURRENT MEDICATION**_____

_____

_____

_____

a. Indicate signs to be watched for in respect of re-evaluation _____

_____

b. Follow-up dates for tests, surgery and repeat prescriptions_____

7. GENERAL REMARKS

_____

_____

_____

_____

_____

PLACE:_____ DATE:_____

SIGNED (General practitioner/District Surgeon)_____

PRINT NAME: _____

PRACTICE NUMBER: _____