

**Medical Examination Form**  
**for Residents in Residential Care Homes for Persons with Disabilities**  
**殘疾人士院舍住客體格檢驗報告書**

<b>Part I</b> 第一部分	<b>Particulars of Resident</b> 住客資料
<b>Name</b> 姓名	<b>Sex</b> 性別
<b>Age/Date of Birth</b> 年齡/出生日期	
<b>HKIC No.</b> 香港身份證號碼	<b>Hospital/Clinic Ref. No.</b> 醫院/診所檔號

<b>Part II</b> 第二部分	<b>Types of Disability/Medical History</b> 殘疾類別/病歷
(1)	Types of disability (diagnosed by clinical psychologists/medical practitioners) 殘疾類別（經臨床心理學家/醫生診斷）： <input type="checkbox"/> Mentally Handicapped, please indicate the level 智障，請表明程度 <input type="checkbox"/> mild 輕度 <input type="checkbox"/> moderate 中度 <input type="checkbox"/> severe 嚴重 <input type="checkbox"/> profound 極度嚴重 <input type="checkbox"/> Physically Handicapped, please specify: 肢體傷殘，請說明： _____ <input type="checkbox"/> Mentally Ill, please specify: 精神病，請說明： _____ Last hospitalization 最近入住醫院記錄： _____ <input type="checkbox"/> Others, please specify: 其他，請說明： _____
(2)	Any history of major illnesses/operations? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span> 曾否患嚴重疾病/接受大型手術？ <span style="float: right;">有      無</span> If yes, please specify the diagnosis: 如有，請註明診斷結果： _____
(3)	Any allergy to food or drugs? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span> 有否食物或藥物過敏？ <span style="float: right;">有      無</span> If yes, please specify: 如有，請註明： _____
(4)	Any diagnosis of epilepsy? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span> 是否患有腦癇症？ <span style="float: right;">有      無</span> If yes, please indicate the number of seizures within the past 1 month: 如有，請表明過去一個月發作次數： _____
(5)	Any recent auditory/visual deterioration? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span> 近期有否聽覺/視覺退化？ <span style="float: right;">有      無</span> If yes, please specify: 如有，請註明： _____
(6)	Any signs of infectious disease? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span> 有否傳染病徵狀？ <span style="float: right;">有      無</span> If yes, please specify: 如有，請註明： _____
(7)	Any swallowing difficulties/easy choking? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span> 有否吞嚥困難/容易哽塞？ <span style="float: right;">有      無</span> If yes, please specify: 如有，請註明： _____

(8)	Any need of special diet? 有否特別膳食需要？ If yes, please specify: 如有，請註明： _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(9)	Any record of travelling within the past 6 months? 過去 6 個月有否外遊記錄？ If yes, please specify: 如有，請註明： _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(10)	Details of present medication, if any, including the name and dosage. 如目前需服用藥物，請詳述藥名及服用量。  _____ _____		

**Part III Physical Examination**  
**第三部分 身體檢查**

Blood Pressure 血壓	Pulse 脈搏	Body Weight 體重
mmHg	/min	kg
<b>Please specify:</b> 請註明：		
<b>Cardiovascular System</b> 循環系統	_____	
<b>Respiratory System</b> 呼吸系統	_____	
<b>Central Nervous System</b> 中樞神經系統	_____	
<b>Musculo-skeletal</b> 肌骨	_____	
<b>Abdomen/Urogenital System</b> 腹／泌尿及生殖系統	_____	
<b>Lymphatic System</b> 淋巴系統	_____	
<b>Thyroid</b> 甲狀腺	_____	
<b>Skin Condition, e.g. scabies</b> 皮膚狀況，如：疥瘡	_____	
<b>Foot</b> 足部	_____	
<b>Eye/Ear, Nose and Throat</b> 眼／耳鼻喉	_____	
<b>Oral/Dental Condition</b> 口腔／牙齒狀況	_____	
<b>Others</b> 其他	_____	

<b>Part IV</b>		<b>Functional Assessment</b>			
<b>第四部分</b>		<b>身體機能評估</b>			
<b>Vision</b> 視力 (with/without* visual corrective devices 有/沒有*配戴 視力矯正器)	<input type="checkbox"/> normal 正常	<input type="checkbox"/> unable to read newspaper print 不能閱讀報紙字體	<input type="checkbox"/> unable to watch TV 不能觀看到電視	<input type="checkbox"/> see lights only 只能見光影	
<b>Hearing</b> 聽覺 (with/without* hearing aids 有/沒有*配戴 助聽器)	<input type="checkbox"/> normal 正常	<input type="checkbox"/> difficult to communicate with normal voice 普通聲量下難以溝 通	<input type="checkbox"/> difficult to communicate with loud voice 大聲說話的情況 下也難以溝通	<input type="checkbox"/> cannot communicate with loud voice 大聲說話的情況 下也不能溝通	
<b>Speech</b> 語言能力	<input type="checkbox"/> able to express 能正常表達	<input type="checkbox"/> need time to express 需慢慢表達	<input type="checkbox"/> need clues to express 需靠提示表達	<input type="checkbox"/> unable to express 不能以語言表達	
<b>Mental state</b> 精神狀況	<input type="checkbox"/> normal/alert/ stable 正常/敏銳 /穩定	<input type="checkbox"/> mildly disturbed 輕度受困擾	<input type="checkbox"/> moderately disturbed 中度受困擾	<input type="checkbox"/> seriously disturbed 嚴重受困擾	
<b>Mobility</b> 活動能力	<input type="checkbox"/> independent 行動自如	<input type="checkbox"/> self-ambulatory with walking aid or wheelchair 可自行用助行器或 輪椅移動	<input type="checkbox"/> always need assistance from other people 經常需要別人幫助	<input type="checkbox"/> bedridden 長期卧床	
<b>Contenance</b> 禁制能力	<input type="checkbox"/> normal 正常	<input type="checkbox"/> occasional faecal or urinary incontinence 大/小便偶爾失禁	<input type="checkbox"/> frequent faecal or urinary incontinence 大/小便經常失禁	<input type="checkbox"/> double incontinence 大小便完全失禁	
<b>A.D.L.</b> 自我照顧能力	<input type="checkbox"/> <b>Independent 完全獨立/不需協助</b> (No supervision or assistance needed in all daily living activities, including bathing, dressing, toileting, transfer, urinary and faecal continence and feeding) (於洗澡、穿衣、如廁、位置轉移、大小便禁制及進食方面均無需指導或協助)				
	<input type="checkbox"/> <b>Occasional assistance 偶爾需要協助</b> (Need assistance in bathing and supervision or assistance in other daily living activities) (於洗澡時需要協助及於其他日常生活活動方面需要指導或協助)				
	<input type="checkbox"/> <b>Frequent assistance 經常需要協助</b> (Need supervision or assistance in bathing and no more than 4 other daily living activities) (於洗澡及其他不超過四項日常生活活動方面需要指導或協助)				
	<input type="checkbox"/> <b>Totally dependent 完全需要協助</b> (Need assistance in all daily living activities) (於日常生活活動方面均需要完全的協助)				
<b>Others</b> 其他	(e.g. aggressive behaviour, self-injurious behaviour, etc.) (例如：攻擊行為、自我傷害行為等)				
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Part V 第五部分	Recommendations 建議
<input type="checkbox"/>	<p>1. <b>Low Care Level Home 低度照顧院舍</b>                      (an establishment providing residential care for persons with disabilities (PWDs) who are capable of basic self-care and require only minimal assistance in daily living activities)                      （即提供住宿照顧予殘疾人士的機構，而該等殘疾人士具備基本的自我照顧能力，而在日常起居方面只需低度協助）</p>
<input type="checkbox"/>	<p>2. <b>Medium Care Level Home 中度照顧院舍</b>                      (an establishment providing residential care for PWDs who are capable of basic self-care but have a degree of difficulty in daily living activities)                      （即提供住宿照顧予殘疾人士的機構，而該等殘疾人士具備基本的自我照顧能力，但在日常起居方面有一定程度的困難）</p>
<input type="checkbox"/>	<p>3. <b>High Care Level Home 高度照顧院舍</b>                      (an establishment providing residential care for PWDs who are generally weak in health and lack basic self-care skill to the extent that they require personal care, attention and assistance in the course of daily living activities but do not require a high degree of professional medical or nursing care)                      （即提供住宿照顧予殘疾人士的機構，而該等殘疾人士一般健康欠佳並缺乏基本的自我照顧技巧，程度達到他們在日常起居方面需要專人照顧、護理及協助，但不需要高度的專業醫療或護理）</p>

Part VI 第六部分	Other Comment 其他批註
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**Registered Medical Practitioner's Signature**

註冊醫生簽署

\_\_\_\_\_

**Name of Hospital/Clinic**

醫院／診所名稱

\_\_\_\_\_

**Registered Medical Practitioner's Name**

註冊醫生姓名

\_\_\_\_\_

**Stamp of Hospital/Clinic/  
Registered Medical Practitioner**

醫院／診所／註冊醫生印鑑

\_\_\_\_\_

**Date**

日期

\_\_\_\_\_