

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

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

Part II	Types of Disability/Medical History		
第二部分	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? 曾否患嚴重疾病／接受大型手術？ If yes, please specify the diagnosis: 如有，請註明診斷結果：	Yes <input type="checkbox"/> 有	No <input type="checkbox"/> 無
(3)	Any allergy to food or drugs? 有否食物或藥物過敏？ If yes, please specify: 如有，請註明：	Yes <input type="checkbox"/> 有	No <input type="checkbox"/> 無
(4)	Any diagnosis of epilepsy? 是否患有腦癇症？ 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：	Yes <input type="checkbox"/> 有	No <input type="checkbox"/> 無
(5)	Any recent auditory/visual deterioration? 近期有否聽覺／視覺退化？ If yes, please specify: 如有，請註明：	Yes <input type="checkbox"/> 有	No <input type="checkbox"/> 無
(6)	Any signs of infectious disease? 有否傳染病徵狀？ If yes, please specify: 如有，請註明：	Yes <input type="checkbox"/> 有	No <input type="checkbox"/> 無
(7)	Any swallowing difficulties/easy choking? 有否吞嚥困難／容易哽塞？ If yes, please specify: 如有，請註明：	Yes <input type="checkbox"/> 有	No <input type="checkbox"/> 無

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

Part IV 第四部分		Functional Assessment 身體機能評估			
Vision 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	
Hearing 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	
Speech 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	
Mental state 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	
Mobility 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	
Contenance 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	
A.D.L. 自我照顧能力	<input type="checkbox"/> Independent 完全獨立/不需協助 (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"/> Occasional assistance 偶爾需要協助 (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"/> Frequent assistance 經常需要協助 (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"/> Totally dependent 完全需要協助 (Need assistance in all daily living activities) (於日常生活活動方面均需要完全的協助)				
Others 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. Low Care Level Home 低度照顧院舍 (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. Medium Care Level Home 中度照顧院舍 (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. High Care Level Home 高度照顧院舍 (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
