Medical Report *(To be filled by a Doctor as applicable)*

1. Medical History & Diagnosis

2. Communication Abilities

3. Psychological State
   - Fully Oriented
   - Occasionally Confused
   - Confused
   - Disoriented

4. Behavioural State
   - Good
   - Apathetic
   - Aggressive
   - Wandering

5. ADLs *(Activities of Daily Living)*

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<th>Independent</th>
<th>Assisted</th>
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6. List of Medications

7. Social Situation
   - The applicant:  
     - Lives Alone
     - Lives with Someone Else
     - Support Social Network

8. Domiciliary Allied Health Intervention
   - Applicable only for the frail, vulnerable and those who cannot exit own homes.
   - Yes
   - No

9. For Continence Service kindly indicate a valid clinical reason. If pull ups are being requested specify reason why pull ups and not another product ___________________________________________________________ _________________________________________________________________________

10. Other Relevant Information *(include other clinics / services used)*

______________________________  ______________________________  ___________________________
Name & Surname *(Doctor)*       Medical Council Number       Signature *(Doctor)*

______________________________  __________________________
Contact No. *(Doctor)*          Date

Rubber Stamp