



**Physical Address:** 17 Hutchinson Road, Umbilo, 4001  
**Postal Address:** PO Box 17079, Congella, 4013

**Telephone:** 031 205 1351  
**Fax:** 031 205 4288

**NPO Number:** 002-243

**KZN Care Association**

*Helping Hands Caring Hearts*

**Medical Report**

To be completed by a Doctor upon Examination of person applying for Residence

Full Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Past Medical History:

\_\_\_\_\_

Previous treatment: \_\_\_\_\_

Present Symptoms: \_\_\_\_\_

Which Hospital did you receive treatment? \_\_\_\_\_

**General Examination:**

General Physical & Nutritional State: \_\_\_\_\_

Respiratory System: \_\_\_\_\_

Cardiovascular System: \_\_\_\_\_

Blood Pressure (To Be Taken In All Cases): \_\_\_\_\_

Genito-Urinary/Urine to Be Tested (In All Cases): \_\_\_\_\_

Digestive & Other Abdominal Systems: \_\_\_\_\_

Muscular & Skeletal System (State Defects): \_\_\_\_\_

Central Nervous System (State Defects): \_\_\_\_\_

Mental Condition: \_\_\_\_\_

Is Patient Free From Infectious & Contagious Diseases: \_\_\_\_\_

If no, provide details: \_\_\_\_\_

Any Other Condition Not Included In Classification Above: \_\_\_\_\_

Present Medication \_\_\_\_\_

Any Further Medication: \_\_\_\_\_

Any Allergies: \_\_\_\_\_

Weight: \_\_\_\_\_

General Remarks: \_\_\_\_\_

\_\_\_\_\_

How Long Has the Client Been Your Patient? \_\_\_\_\_

Signed at \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_.

\_\_\_\_\_  
Medical Practitioner Signature

STAMP: