St Francis CARE CENTRE
Dedicated to comfort, care & compassion
APCC ASSOCIATION OF PALLIATIVE CARE CENTRES
VALIDATED ORGANIZATION CAF GROUP
011-894-4151
secretary@stfranciscarecentre.co.za
30 Olivia Rd, Eveleigh, Boksburg, 1459
Registration No: 011-441 NPO / Practise No: 079 0000470546 / VAT No: 4490178623 / PBO No: 18/11/13/3746

MEDICAL REPORT FOR PATIENT ADMISSION

Please complete this medical report and submit it together with the patient's completed Admission Application Form.

1. PATIENT INFORMATION

Full Name & Surname: _____

ID / Passport Number: _____

Date of Birth: _____ **Age:** _____ **Gender:** _____

Contact Number: _____

Date of Report: _____

Admission Date: _____

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2. PRIMARY DIAGNOSIS

Primary Diagnosis:

ICD-10 Code: _____

Date of Diagnosis: _____

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3. RELEVANT PAST MEDICAL HISTORY

Please provide details of significant previous medical conditions, surgeries, hospitalisations, procedures, or other relevant history:

DATE OF ADMISSION	HOSPITAL	REASON / PROCEDURE	DISCHARGE DATE

Previous Operations / Procedures:

Known Allergies:
☐ None Known ☐ Yes – please specify: _____

4. CURRENT CLINICAL CONDITION

Current Functional Status:
☐ Independent ☐ Requires Assistance ☐ Fully Dependent ☐ Bedbound

Mobility:
☐ Independent ☐ Walking Aid ☐ Wheelchair ☐ Bedbound

Cognitive / Mental Status:
☐ Alert & Orientated ☐ Confused ☐ Reduced Consciousness ☐ Dementia Other :_____

Current Symptoms / Clinical Concerns:
☐ Pain
☐ Shortness of Breath
☐ Nausea / Vomiting
☐ Reduced Appetite
☐ Weakness / Fatigue
☐ Anxiety / Distress
☐ Wounds / Pressure Injuries
☐ Other: _____

Current Clinical Summary:

5. CURRENT TREATMENT & MEDICATION

Current Medication:

Pain Management:

Other Symptom Management:

6. SPECIAL CARE REQUIREMENTS

Please indicate any additional care or equipment required:

☐ Pressure Care / Special Mattress
☐ Wound Care
☐ Catheter Care
☐ Stoma Care
☐ Feeding Assistance
☐ PEG / Enteral Feeding
☐ Oxygen Therapy
☐ Continence Care
☐ Mobility Assistance
☐ Other: _____

Additional Nursing / Clinical Requirements:

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7. MEDICAL PROFESSIONAL DETAILS

Completed By – Full Name:

Professional Designation:

Practice / Facility:

HPCSA Registration Number: _____

Practice Number: _____

Contact Number: _____

Email Address: _____

Date Completed: _____

Signature: _____

Official Stamp: