SG ENABLE
Inclusive society, Enabled lives.

MEDICAL INFORMATION (page 1 of 2)

(To be completed by a fully registered medical practitioner.)

Name of Applicant: _____ **NRIC / BC No.:** _____

Please tick ☑ where appropriate.

TYPE OF DISABILITY (Multiple selection allowed for multiple disabilities condition)			**PRIMARY DIAGNOSIS**
Diagnosis	Intellectual Disability (IQ level: below 70)	Borderline ID (IQ level: 70 – 80)	
❑ Intellectual Condition	❑	❑	❑

Diagnosis	**Partial Impairment**	**Total Impairment**	**PRIMARY DIAGNOSIS**
❑ Sensory (Visual) : _____	❑	❑	❑
❑ Sensory (Hearing): _____	❑	❑	❑
❑ Sensory (Others) : _____	❑	❑	❑

Diagnosis	**Mild**	**Moderate**	**Severe**	**PRIMARY DIAGNOSIS**
❑ Autism Spectrum Disorder (ASD)	❑	❑	❑	❑
❑ Physical Disability (Please specify): _____	❑	❑	❑	❑
❑ Developmental Condition (Please specify): _____	❑	❑	❑	❑
❑ Other Disabilities (Please specify): _____	❑	❑	❑	❑

MEDICAL HISTORY

(a) Mental or psychiatric disorders

❑ No – *Please move on to Question (b)* ❑ Yes, please specify: _____

Condition: ❑ Mild ❑ Moderate ❑ Severe

(b) Infectious diseases

❑ No – *Please move on to Question (c)* ❑ Yes, please specify: _____

Following up: ❑ Yes ❑ No ❑ Discharged ❑ Defaulted

Date of last follow-up: _____ Hospital / clinic: _____

Condition: ❑ Active or highly contagious ❑ Persistent and asymptomatic ❑ No longer infectious or contagious

DOCTOR'S CERTIFICATION - IF APPLICABLE (page 1 of 2)

Name of Doctor		Signature of Doctor	Official stamp of hospital/ clinic:
Date (DD/MM/YYYY)	MCR No.	Contact No.	

MEDICAL INFORMATION (page 2 of 2)

(To be completed by a fully registered medical practitioner.)

Name of Applicant: _____ **NRIC / BC No.:** _____

Please tick ☑ where appropriate.

(c) Medical conditions

- ❑ Respiratory: _____
- ❑ Cardiovascular: _____
- ❑ Endocrine / Metabolic: _____
- ❑ Neurological disorders: _____
- ❑ Musculoskeletal: _____
- ❑ Dermatological conditions: _____
- ❑ Other condition(s) not specified above: _____

If any of the above is ticked, please elaborate (e.g. frequency of occurrence): _____

_____

(d) Did patient undergo any surgery within the last two years? If yes, please provide brief details:

	Date	**Surgery done**
❑ No ❑ Yes		

(e) Is patient currently on any medication?

	If yes, please specify:	
❑ No ❑ Yes	1.	6.
	2.	7.
	3.	8.
	4.	9.
	5.	10.

(f) Does patient have any drug allergies?

	If yes, please specify:	
❑ No ❑ Yes	1.	3.
	2.	4.

(g) Does patient have any regular follow-ups?

	If yes, please specify:	
	Types of follow up	**Frequency**
❑ No ❑ Yes		

DOCTOR'S CERTIFICATION - IF APPLICABLE (page 2 of 2)

Name of Doctor		Signature of Doctor	Official stamp of hospital/ clinic:
Date (DD/MM/YYYY)	MCR No.	Contact No.	