Western Cape Government

Department of Social Development
Directorate Facility Management
Centralised Admissions
R101 Old Paarl Road, De Novo, Kraaifontein, 7570
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Tel: 021826 6026

MEDICAL CERTIFICATE

This report must be completed by a medical practitioner.

1. PATIENT INFORMATION					
Name and Surname					
Date of Birth					
2. MEDICAL HISTORY (INCLUDE OPERATIONS)					
Have you treated the patient before?			Yes		No
Is the patient currently under your medical treatment?			Yes		No
If "yes" what was/is the diagnosis:					
Current chronic conditions:					
Current prescribed medication (attach a copy of the prescription):					
3. PHYSICAL EXAMINATION					
Blood sugar (HGT)		Weight			
Haemoglobin (HB)		Eyes			
Blood pressure		Allergies			
Ear/Nose/Throat		Temperature			
Urine Test		Pregnancy	Yes	No	
Teeth		Last Menstruation cycle			
Respiratory		Family Planning	Yes	No	
Cardiovascular		TB Screening			
Neurological		History of TB	Yes	No	
Abdominal		TB Symptoms	Yes	No	
Dermatological		In contact with TB patient	Yes	No	
Mobility	Moves Freely	Moves with Difficulty	Makes use of assistive device		
Is this patient physically stable for admission?		Yes	No		
4. PSYCHIATRIC HISTORY (psychosis, suicide attempts, depression, DT'S, admissions, medication etc)					
Is action in terms of the Mental Health Act required?		Yes	No		
If not is psychiatric treatment required?		Yes	No		
Provide more information:					
Is detoxification required (Excl. Opioids, benzodiazepines, Alcohol which are compulsory)			Yes	No	
Is the patient psychiatrically stable for admission?			Yes	No	
5. INFORMATION OF MEDICAL PRACTITIONER					
Name and Surname		Contact Number			
Qualification		Address			
Practice number		Date			
Signature					