

Medical Examination Form
for Residents in Residential Care Homes for the Elderly
安老院住客體格檢驗報告書

Part I Particulars of Resident**第一部分 住客資料**

Name 姓名 _____	Sex 性別 _____	Age 年齡 _____
HKIC No. 香港身分證號碼 _____	Hospital / Clinic Ref. No. 醫院／診所檔案 _____	

Part II Medical History**第二部分 病歷**

- | | | | |
|--|------------------------------|-----------------------------|--|
| (1) Any history of major illnesses / operations ?
曾否患嚴重疾病 / 接受大型手術？
If yes, please specify the diagnosis :
如有，請註明診斷結果： _____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| (2) Any allergy to food or drugs ?
有否食物或藥物過敏？
If yes, please specify :
如有，請註明： _____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| (3) (a) Any signs of infectious disease ?
有否傳染病徵狀？
If yes, please specify :
如有，請註明： _____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| (3) (b) Any further investigation or treatment required ?
是否需要接受跟進檢查或治療？
If yes, please specify and also state hospital/clinic attended and reference number.
如有，請註明並填寫覆診的醫院 / 診所和檔號。 _____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| (4) Any swallowing difficulties / easy choking ?
有否吞嚥困難 / 容易哽塞？
If yes, please specify :
如有，請註明： _____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| (5) Any need of special diet ?
有否特別膳食需要？
If yes, please specify :
如有，請註明： _____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| (6) Past psychiatric history, if any, including the diagnosis, period and whether regular follow-up treatment is required.
如過往有精神病紀錄，請詳述病歷及是否需要定期覆診。
_____ | | | |
| (7) Detail of present medication, if any.
如目前須服用藥物，請詳述藥名及服用量。

_____ | | | |

Part III Physical Examination		
第三部分 身體檢查		
Blood pressure 血壓	Pulse 脈搏	Body Weight 體重
mmHg	/min	kg
Please specify : 請註明：		
Cardiovascular System 循環系統	_____	
Respiratory System 呼吸系統	_____	
Central Nervous System 中樞神經系統	_____	
Musculo-skeletal 肌骨	_____	
Abdomen/Urogenital 腹/泌尿及生殖系統	_____	
Lymphatic System 淋巴系統	_____	
Thyroid 甲狀腺	_____	
Skin Condition, e.g. pressure injuries (pressure sores) 皮膚狀況，如：壓力性損傷（壓瘡）	_____	
Foot 足部	_____	
Eye / Ear , Nose and Throat 眼／耳鼻喉	_____	
Oral / Dental Condition 口腔／牙齒狀況	_____	
Others 其他	_____	

Part IV Functional Assessment
第四部分 身體機能評估

Vision 視力 (with/without* visual corrective devices 有/沒有*配戴 視力矯正器)	<input type="checkbox"/> normal 正常	<input type="checkbox"/> unable to read newspaper print 不能閱讀報紙字體	<input type="checkbox"/> unable to watch TV 不能觀看到電視	<input type="checkbox"/> see lights only 只能見光影
Hearing 聽覺 (with/without* hearing aid) 有/沒有*配戴 助聽器)	<input type="checkbox"/> normal 正常	<input type="checkbox"/> difficult to communicate with normal voice 普通聲量下難以溝 通	<input type="checkbox"/> difficult to communicate with loud voice 大聲說話的情況 下也難以溝通	<input type="checkbox"/> cannot communicate with loud voice 大聲說話的情況 下也不能溝通
Speech 語言能力	<input type="checkbox"/> able to express 能正常表達	<input type="checkbox"/> need time to express 需慢慢表達	<input type="checkbox"/> need clues to express 需靠提示表達	<input type="checkbox"/> unable to express 不能以言語表達
Mental state 精神狀況	<input type="checkbox"/> normal/alert stable 正常/敏銳 /穩定	<input type="checkbox"/> mildly disturbed 輕度受困擾	<input type="checkbox"/> moderately disturbed 中度受困擾	<input type="checkbox"/> seriously disturbed 嚴重受困擾
Mobility 活動能力	<input type="checkbox"/> independent 行動自如	<input type="checkbox"/> self-ambulatory with walking aid or wheelchair 可自行用助行器或 輪椅移動	<input type="checkbox"/> always need assistance from other people 經常需要別人幫助	<input type="checkbox"/> bedridden 長期臥床
Continence 禁制能力	<input type="checkbox"/> normal 正常	<input type="checkbox"/> occasional faecal or urinary incontinence 大/小便偶爾失禁	<input type="checkbox"/> frequent faecal or urinary incontinence 大/小便經常失禁	<input type="checkbox"/> double incontinence 大小便完全失禁
A.D.L. 自我照顧能力	<input type="checkbox"/> Independent 完全獨立/不需協助 (No supervision or assistance needed in all daily living activities, including bathing, dressing, toileting, transfer, urinary and faecal continence and feeding.) (於洗澡、穿衣、如廁、位置轉移、大小便禁制及進食方面均無需指導或協助)			
	<input type="checkbox"/> Occasional assistance 偶爾需要幫助 (Need assistance in bathing and supervision or assistance in other daily living activities) (於洗澡時需要協助及於其他日常生活活動方面需要指導或協助)			
	<input type="checkbox"/> Frequent assistance 經常需要幫助 (Need supervision or assistance in bathing and no more than 4 other daily living activities) (於洗澡及其他不超過四項日常生活活動方面需要指導或協助)			
	<input type="checkbox"/> Totally dependent 完全需要幫助 (Need assistance in all daily living activities) (於日常生活活動方面均需要完全的協助)			

Part V Recommendation
第五部分 建議

The applicant is fit for admission to the following type of residential care homes for the elderly -
 申請人適合入住以下類別的安老院：

- 1. **Self-care Hostel 低度照顧安老院**
 (an establishment providing residential care, supervision and guidance for persons who have attained the age of 60 years and who are capable of observing personal hygiene and performing household duties related to cleaning, cooking, laundering, shopping and other domestic tasks)
 (即提供住宿照顧、監管及指導予滿 60 歲人士的機構，而該等人士有能力保持個人衛生，亦有能力處理關於清潔、烹飪、洗衣、購物的家居工作及其他家務)

- 2. **Aged Home 中度照顧安老院**
 (an establishment providing residential care, supervision and guidance for persons who have attained the age of 60 years and who are capable of observing personal hygiene but have a degree of difficulty in performing household duties related to cleaning, cooking, laundering, shopping and other domestic tasks)
 (即提供住宿照顧、監管及指導予滿 60 歲人士的機構，而該等人士有能力保持個人衛生，但在處理關於清潔、烹飪、洗衣、購物的家居工作及其他家務方面，有一定程度的困難)

- 3. **Care-and-Attention Home 高度照顧安老院**
 (an establishment providing residential care, supervision and guidance for persons who have attained the age of 60 years and who are generally weak in health and are suffering from a functional disability to the extent that they require personal care and attention in the course of daily living activities but do not require a high degree of professional medical or nursing care)
 (即提供住宿照顧、監管及指導予滿 60 歲人士的機構，而該等人士一般健康欠佳，而且身體機能喪失或衰退，以致在日常起居方面需要專人照顧料理，但不需要高度的專業醫療或護理)

Part VI Other Comment
第六部分 其他批註

Medical Practitioner's Signature

醫生簽署 _____

Name of Hospital/Clinic

醫院/診所名稱 _____

Medical Practitioner's Name

醫生姓名 _____

Stamp of Hospital/Clinic/

Medical Practitioner

醫院/診所/醫生印鑑 _____

Date

日期： _____