**Medical Examination Form  
for Residents in Residential Care Homes for Persons with Disabilities  
殘疾人士院舍住客體格檢驗報告書**

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| **Part I 第一部分** | | | **Particulars of Resident 住客資料** | | | | | | | | | | | | | | | | |
| **Name 姓名** | |  | | | | | **Sex 性別** |  | | | | | **Age/Date of Birth 年齡／出生日期** | | |  | | |  |
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| **HKIC No. 香港身份證號碼** | | | | |  | | | | | **Hospital/Clinic Ref. No. 醫院／診所檔號** | | | |  | | | | |  |
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| **Part II 第二部分** | | | **Types of Disability/Medical History 殘疾類別／病歷** | | | | | | | | | | | | | | | | |
| (1) | Types of disability (diagnosed by clinical psychologists/medical practitioners) 殘疾類別（經臨床心理學家／醫生診斷）： | | | | | | | | | | | | | | | | | | |
|  | Mentally Handicapped, please indicate the level弱智，請表明程度 | | | | | | | | | | | | | | | | | | |
|  |  | | | mild輕度 moderate中度 severe嚴重 profound極度嚴重 | | | | | | | | | | | | | | | |
|  | Physically Handicapped, please specify: 肢體傷殘，請說明： | | | | | | | | | | | | | | | | | | |
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|  | Mentally Ill, please specify: 精神病，請說明： | | | | | | | | | | | | | | | | | |  |
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|  |  | | | Last hospitalization最近入住醫院記錄： | | | | | | | | |  | | | | | |  |
|  | Others, please specify: 其他，請說明： | | | | | | | | | | |  | | | | | | |  |
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| (2) | Any history of major illnesses/operations? 曾否患嚴重疾病／接受大型手術？ | | | | | | | | | | | | | Yes  有 | | | No  無 | | |
|  | If yes, please specify the diagnosis: 如有，請註明診斷結果： | | | | | | | |  | | | | | | | | | |  |
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| (3) | Any allergy to food or drugs? 有否食物或藥物過敏？ | | | | | | | | | | | | | Yes  有 | | | No  無 | | |
|  | If yes, please specify: 如有，請註明： | | | | |  | | | | | | | | | | | | |  |
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| (4) | Any diagnosis of epilepsy? 是否患有腦癇症？ | | | | | | | | | | | | | Yes  有 | | | No  無 | | |
|  | If yes, please indicate the number of seizures within the past 1 month: 如有，請表明過去一個月發作次數： | | | | | | | | | | | | | |  | | |  | |
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| (5) | Any recent auditory/visual deterioration? 近期有否聽覺／視覺退化？ | | | | | | | | | | | | | Yes  有 | | | No  無 | | |
|  | If yes, please specify: 如有，請註明： | | | | |  | | | | | | | | | | | |  | |
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| (6) | Any signs of infectious disease? 有否傳染病徵狀？ | | | | | | | | | | | | | Yes  有 | | | No  無 | | |
|  | If yes, please specify: 如有，請註明： | | | | |  | | | | | | | | | | | |  | |
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| (7) | Any swallowing difficulties/easy choking? 有否吞嚥困難／容易哽塞？ | | | | | | | | | | | | | Yes  有 | | | No  無 | | |
|  | If yes, please specify: 如有，請註明： | | | | |  | | | | | | | | | | | | |  |
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| (8) | Any need of special diet? 有否特別膳食需要？ | | | | | | | | | | | Yes  有 | No  無 | | |
|  | If yes, please specify: 如有，請註明： | | | | |  | | | | | | | | |  |
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| (9) | Any record of travelling within the past 6 months? 過去6個月有否外遊記錄？ | | | | | | | | | | | Yes  有 | No  無 | | |
|  | If yes, please specify: 如有，請註明： | | | | |  | | | | | | | | |  |
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| (10) | Details of present medication, if any, including the name and dosage. 如目前需服用藥物，請詳述藥名及服用量。 | | | | | | | | | | | | | | |
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| **Part III 第三部分** | | **Physical Examination 身體檢查** | | | | | | | | | | | | | |
| **Blood Pressure血壓** | | | | | | | **Pulse脈搏** | | | | **Body Weight體重** | | | | |
|  | | | | mmHg | | |  | | /min | |  | | | kg | |
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|  | | | | | **Please specify: 請註明：** | | | | | | | | | | |
| **Cardiovascular System 循環系統** | | | | |  | | | | | | | | | |  |
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| **Respiratory System 呼吸系統** | | | | |  | | | | | | | | | |  |
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| **Central Nervous System 中樞神經系統** | | | | |  | | | | | | | | | |  |
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| **Musculo-skeletal 肌骨** | | | | |  | | | | | | | | | |  |
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| **Abdomen/Urogenital System 腹／泌尿及生殖系統** | | | | |  | | | | | | | | | |  |
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| **Lymphatic System 淋巴系統** | | | | |  | | | | | | | | | |  |
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| **Thyroid 甲狀腺** | | | | |  | | | | | | | | | |  |
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| **Skin Condition, e.g. scabies 皮膚狀況，如：疥瘡** | | | | |  | | | | | | | | | |  |
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| **Foot 足部** | | | | |  | | | | | | | | | |  |
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| **Eye/Ear, Nose and Throat 眼／耳鼻喉** | | | | |  | | | | | | | | | |  |
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| **Oral/Dental Condition 口腔／牙齒狀況** | | | | |  | | | | | | | | | |  |
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| **Others 其他** | | | | |  | | | | | | | | | |  |
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| **Part IV 第四部分** | **Functional Assessment**  **身體機能評估** | | | | | | | | |
| **Vision**  **視力**  (with/without\* visual corrective devices  有／沒有\*配戴  視力矯正器) |  | normal  正常 |  | unable to read newspaper print  不能閱讀報紙字體 |  | unable to watch TV  不能觀看到電視 |  | see lights only  只能見光影 | |
| **Hearing**  **聽覺**  (with/without\*  hearing aids  有／沒有\*配戴  助聽器) |  | normal  正常 |  | difficult to communicate with normal voice  普通聲量下難以溝通 |  | difficult to communicate with loud voice  大聲說話的情況下也難以溝通 |  | cannot communicate with loud voice  大聲說話的情況下也不能溝通 | |
| **Speech**  **語言能力** |  | able to express  能正常表達 |  | need time to express  需慢慢表達 |  | need clues to express  需靠提示表達 |  | unable to express  不能以語言表達 | |
| **Mental state**  **精神狀況** |  | normal/alert/  stable  正常／敏銳／穩定 |  | mildly disturbed  輕度受困擾 |  | moderately disturbed  中度受困擾 |  | seriously disturbed  嚴重受困擾 | |
| **Mobility**  **活動能力** |  | independent  行動自如 |  | self-ambulatory with walking aid or wheelchair  可自行用助行器或輪椅移動 |  | always need assistance from other people  經常需要別人幫助 |  | bedridden  長期卧床 | |
| **Continence**  **禁制能力** |  | normal  正常 |  | occasional faecal or urinary incontinence  大／小便偶爾失禁 |  | frequent faecal or urinary incontinence  大／小便經常失禁 |  | double incontinence  大小便完全失禁 | |
| **A.D.L.**  **自我照顧能力** |  | **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） | | | | | | | |
|  |  | **Occasional assistance 偶爾需要協助**  (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） | | | | | | | |
|  |  | **Frequent assistance 經常需要協助**  (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） | | | | | | | |
|  |  | **Totally dependent完全需要協助**  (Need assistance in all daily living activities) （於日常生活活動方面均需要完全的協助） | | | | | | | |
| **Others**  **其他** |  | (e.g. aggressive behaviour, self-injurious behaviour, etc.) （例如：攻擊行為、自我傷害行為等） | | | | | | | |
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| **Part V 第五部分** | | | **Recommendations**  **建議** | | | | | | |
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|  |  | **Low Care Level Home低度照顧院舍** | | | | | | | |
|  |  | (an establishment providing residential care for persons with disabilities (PWDs) who are capable of basic self-care and require only minimal assistance in daily living activities)  （即提供住宿照顧予殘疾人士的機構，而該等殘疾人士具備基本的自我照顧能力，而在日常起居方面只需低度協助） | | | | | | | |
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|  |  | **Medium Care Level Home中度照顧院舍** | | | | | | | |
|  |  | (an establishment providing residential care for PWDs who are capable of basic self-care but have a degree of difficulty in daily living activities)  （即提供住宿照顧予殘疾人士的機構，而該等殘疾人士具備基本的自我照顧能力，但在日常起居方面有一定程度的困難） | | | | | | | |
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|  |  | **High Care Level Home高度照顧院舍** | | | | | | | |
|  |  | (an establishment providing residential care for PWDs who are generally weak in health and lack basic self-care skill to the extent that they require personal care, attention and assistance in the course of daily living activities but do not require a high degree of professional medical or nursing care)  （即提供住宿照顧予殘疾人士的機構，而該等殘疾人士一般健康欠佳並缺乏基本的自我照顧技巧，程度達到他們在日常起居方面需要專人照顧、護理及協助，但不需要高度的專業醫療或護理） | | | | | | | |
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| **Part VI 第六部分** | | | | | **Other Comment**  **其他批註** | | | | | |
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| **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** | | | | | |  | |  |  | |