Please tick ⊘ where applicable

Name of Applicant: _____

NRIC / BC No.: _____

M. MEDICAL INFORMATION

Providing medical information below is not required if the applicant can present valid medical proof of their past and presenting health conditions or has no medical conditions. If such proof is unavailable, the applicant should approach a medical practitioner to complete this section.

If a medical report is submitted with the application, a social worker from the referring agency may also provide additional medical background of the applicant on page 19 and 20.

1M. MEDICAL HISTORY

(a) Mental or psychiatric disorders

○ No ○ Yes, Please Specify: _____

Condition ○ Mild ○ Moderate ○ Severe

(b) Infectious Diseases

○ No ○ 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

(c) Medical Conditions

☐ Respiratory: _____ ☐ Neurological Disorder: _____

☐ Cardiovascular: _____ ☐ Musculoskeletal: _____

☐ Endocrine/Metabolic: _____ ☐ Dermatological Conditions: _____

☐ Other condition(s) not specified above: _____

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

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

	Date	Surgery Done
○ No ○ Yes		

(e) Is the patient currently on any medication? If yes, please specify below.

○ No ○ Yes	1.	3.
	2.	4.

(f) Does the patient have any drug allergies? If yes, please specify below.

○ No ○ Yes	1.	3.
	2.	4.

Please tick ⊘ where applicable

M. MEDICAL INFORMATION (CONTINUED)

(g) Does the patient have any food allergies?		If yes, please specify below.
○ No ○ Yes	1.	3.
	2.	4.

(h) Does the patient have any regular follow-ups?		If yes, please specify below.
○ No ○ Yes	Types of follow-up	Frequency

2M. DOCTOR'S CERTIFICATION – IF APPLICABLE

Name of Doctor	Signature.	Date
Contact No	MCR No.	Official Stamp of Hospital/Clinic