

# MEDICAL REPORT

## A IDENTIFYING DETAILS

NAME \_\_\_\_\_ AGE \_\_\_\_\_

ID NO \_\_\_\_\_ SEX \_\_\_\_\_

TRAINING \_\_\_\_\_

OCCUPATION \_\_\_\_\_

## B TO BE COMPLETED AND SIGNED BY MEDICAL PRACTITIONER

ENCIRCLE APPROPRIATE NUMBER

- 0 - NORMAL
- 1 - SLIGHT functional curtailment
- 2 - MODERATE functional curtailment
- 3 - SERIOUS functional curtailment
- 4 - VERY SERIOUS functional curtailment
- 5 - NO function

B1. ENERGY						
Cardiovascular	0	1	2	3	4	5
Respiratory	0	1	2	3	4	5
Miscellaneous HS/Endocrines/Thyroid/Food – too much, too little	0	1	2	3	4	5
B2. CONTROL						
Motor Control	0	1	2	3	4	5
Sensorial Control	0	1	2	3	4	5
Sight	0	1	2	3	4	5
Hearing	0	1	2	3	4	5
B3. OTHER						
Unusual body dimensions	0	1	2	3	4	5
Ability to transfer	0	1	2	3	4	5

## C MEDICAL PRACTITIONER'S FINDING

Specify disability \_\_\_\_\_

\_\_\_\_\_

Is disability permanent yes/no \_\_\_\_\_

If not, specify period \_\_\_\_\_

A special/adapted vehicle is needed/not needed because \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CAPACITY

\_\_\_\_\_  
TELEPHONE NUMBER

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_