FORM E

TIRKANDI INABURRA CULTURAL & DEVELOPMENT CENTRE

PARTICIPANT MEDICAL ASSESMENT FORM

TO BE COMPLETED BY A QUALIFIED MEDICAL PRACTITIONER

NAME OF FAMILY DOCTOR:	
PHONE NUMBER:	
ADDRESS:	
ARE YOU THE CLIENTS REGULAR DOCOTOR? (PLEASE CIRCLE) YES NO	
CLIENTS NAME:	
DATE OF BIRTH:	AGE:
MEDICARE DETAILS: MEDICARE NUMBER:	
REFERENCE NUMBER ON THE CARD IS:	
EXPIRY DATE OF THE MEDICARE CARD IS:	
KNOWN ALLERGIES? (food, medication, bee-sting etc):	
CURRENT MEDICATIONS: (please list all prescribed types & dosage) CONDITION BEING TREATED:	
PRESCRIBING DOCTOR:	
DOCTOR'S PHONE NUMBER:	
DOES THE CLIENT SUFFER FROM: (PLEASE TICK APPROPRIATE BOX) NIGHTMARES: YES NO BED WETTING: YES NO SLEEP WALKING: YES NO	

Telephone: 02 6954 4800 or 1800 759 040
Fax: 02 6954 4855
Postal Address: PO Box 134 COLEMBALLY NSW 2707
Physical Address: Lot 84 Kidman Way COLEAMBALLY NSW 2707
Website: www.tirkandi.org.au

DOES THE CLIENT USE: (PLEASE TICK APPROPRIATE BOX)

DRUGS

ALCOHOL or

CIGARETTES?

PLEASE DESCRIBE, AS THIS INFORMATION IS ESSENTIAL FOR **TIRKANDI INABURRA** STAFF TO ASSESS THE CLIENT AND MANAGE HIS HEALTH AND PROGRESSION WHILST AT THE CENTRE:

HAS THE CLIENT EVER BEEN TO A PSYCHIATRIST? YES NO

NAME OF PSYCHIATRIST? ______

DATE OF APPOINTMENT? ______

DIAGNOSIS? ______

DOES THE CLIENT SUFFER FROM A.D.H.D. OR ANY LEARNING DISORDER? ______

DOES THE CLIENT SUFFER OR EVER SUFFERED FROM ANY OF THE FOLLOWING?

ASTHMA:	YES	NO
GLANDULAR FEVER:	YES	NO
BRONCHITIS:	YES	NO
DIABETES:	YES	NO
HAY FEVER:	YES	NO
FITS OR EPILEPSY:	YES	NO
HEAD LICE:	YES	NO
TONSILLITIS:	YES	NO

COMMENTS:

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SKIN RASHES - CONTAGIOUS (please circle)

RINGWORM: NEGATIVE - POSITIVE

TINEA: NEGATIVE - POSITIVE

IMPETIGO: NEGATIVE - POSITIVE

SCABIES: NEGATIVE - POSITIVE

OTHER (please specify):

EYES: SPECTACLES/CONTACT LENSES/OTHER PROBLEMS?

HEARING: NORMAL/IMPAIRED?

TEETH CONDITION:

DATE OF LAST DENTAL CHECK UP?

ANY OTHER CONDITIONS REQUIRING MEDICAL ATTENTION:

COMMUNICABLE DISEASE: (please circle)

HEPATITIS A: POSITIVE - NEGATIVE

HEPATITIS B: POSITIVE - NEGATIVE

HEPATITIS C: POSITIVE - NEGATIVE

OTHER: (please specify)

OTHER S.T.D:

BLOOD TYPE:

HAS THE CLIENT EVER USED DRUGS? (please indicate as below)

Drug Name	Last Used	How Much	How Often	How Long	Method of Consumption	Comments
Alcohol						
Pot						
Speed						
Cocaine						
Methadone						
Heroine						
Opium						
Prescription Drugs						
Valium						
Temazapam						
Inhalants						
Glue						

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Ecstasy						
PCD						
Shebu						
LSD						
Others						

HAS THE CLIENT EVER NEEDED TO ENTRE A DETOX PROGRAM?

WHEN	WHERE	HOW LONG	DID THE CLIENT COMPLETE THE PROGRAM

PARENT/LEGAL GUARDIAN'S:

I, Parent/Legal Guardian agree to allow all the results of this medical to be disclosed to the Staff of Tirkandi Inaburra Community on a confidential basis.

SIGNATURE: (parent/legal guardian)

DATE:

MEDICAL OFFICER:

I, have examined the above client as requested and indicate with his Parents/legal guardian's approval the results to the relevant tests.

SIGNATURE: (parent/legal guardian)

DATE:

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