P.O. Box 236
Rondebosch
Cape Town, 7701

Tel: 021 448 0760
Fax: 021 448 0761
Email: comcaretrust@mweb.co.za
Website: www.comcare.co.za

MEDICAL REPORT
(To be completed by the Applicant's Psychiatrist)

We require the following information in support of application to COMCARE TRUST for group home living.

NAME OF APPLICANT:_____

DATE OF BIRTH: _____

PSYCHIATRIC DIAGNOSIS:

Primary Diagnosis (Axis I) _____

Secondary Diagnosis – (Axis II) _____

Does the Applicant have an intellectual disability?_____

Does the Applicant have a head injury?_____

MEDICATION: _____

_____

_____

_____

_____

_____

IS THE APPLICANT COMPLIANT WITH HIS/HER TREATMENT? _____
(Administer own medication/attends clinic regularly)

_____

_____

WHEN WAS THE APPLICANT FIRST DIAGNOSED WITH A PSYCHIATRIC DISORDER? _____

NUMBER OF ADMISSIONS TO A PSYCHIATRIC HOSPITAL: _____

DATE OF LAST ADMISSION: _____

REASON FOR LAST ADMISSION: _____

WHAT ARE THE APPLICANT'S PREDOMINANT SYMPTOMS OF HIS/HER PSYCHIATRIC DISORDER?

_____

_____

_____

ARE THESE SYMPTOMS WELL CONTAINED BY HIS/HER MEDICATION ? _____

_____

HAS THE APPLICANT EVER ATTEMPTED SUICIDE, IF SO HOW OFTEN? _____

_____

DOES THE APPLICANT HAVE A HISTORY OF SUBSTANCE ABUSE/DEPENDENCE? _____

_____

IF SO, IS THE APPLICANT CURRENTLY USING ANY SUBSTANCES? _____

_____

DOES THE APPLICANT HAVE ANY PHYSICAL HEALTH CONDITIONS? _____

_____

IF YES, IS THE APPLICANT ON MEDICATION FOR THIS – PLEASE SPECIFY _____

_____

_____

WHY DO YOU THINK THIS APPLICANT IS SUITABLE FOR ACCOMMODATION IN A SUPPORTED GROUP HOME?

_____

_____

_____

_____

PLEASE PROVIDE ANY ADDIONAL INFORMATION TO ASSIST US IN OUR ASSESSMENT OF THIS APPLICANT FOR ACCOMMODATION

_____

_____

_____

_____

_____

_____

_____

PSYCHIATRIST NAME: _____

CONTACT NUMBER: _____

DATE: _____