GAUTENG PROVINCE
SOCIAL DEVELOPMENT
REPUBLIC OF SOUTH AFRICA

Medical Assessment Form **BGW 3/143**

To be completed prior to admission to a rehabilitation facility (Attach to External Referral Form CW 04B)

Form to be completed in duplicate, one copy to remain in the PHC folder

Name:						Surname:						
Id Number/Date of birth:						Clinic Folder Number:						
Name of Facility:												
Referral Source (Dept/Name &Surname/Contact Details):												
Medical History												
Diabetes		Epilepsy		Hypertension		Asthma		Previous/Current TB				
RVD		Thyroid										
Known Mental Illness (specify):												
Medication:												
Current Substance of Use: Tobacco / Alcohol / Cannabis / Cocaine / CAT or Tik / Heroin (nyaope) / Benzos / OTC analgesics / other –												
COVID Vaccination	**Y**	**N**										
Screening: TB	**Y**	**N**	Mental Health			**Y**	**N**					
Physical Examination												
Vitals: BP: Pulse: Temp:												
Weight: Height:												
Bedside Tests												
HGT:			Urine Dipstick:			BHCG	**NEG**	**POS**				
HIV Testing done: Y/N Results			**NEG**	**POS**								
General Examination:												
Signs of withdrawal:												
Cardiovascular:												
Respiratory:												
Abdomen:												
Central Nervous System:												
Musculoskeletal:												
Mental State Examination: Appearance&behavior_____ _____ Mood & affect_____ Thought form & content_____ _____ Other_____						Orientation Time _____ Place _____ Person _____ Suicidal Yes/ No Homicidal Yes/ No Insight Good_____ Fair _____ Poor _____ Risk to Self or Others_____						

Assessment/Diagnosis

Special Investigations ordered

Add barcode reference

Intravenous Drug Use: HIV/Hepatitis screen
Severe alcohol Use: FBC/LFT

Medication Prescribed

Follow up plan

Practitioner's Name & Surname:

Council Number:

Contact details:

Date:

Signature:

Clinic Stamp

Clinician Stamp