

MEDICAL REPORT

(For Admission to MINDS Schools)

NAME: _____

SEX / D.O.B.: _____ BC / NRIC NO: _____

DIAGNOSIS : _____

CAUSE(S) : _____

ONSET OF DISABILITY : _____

CURRENT PROBLEMS(S) : _____

BIRTH HISTORY

PAST MEDICAL HISTORY

MEDICATION: YES / NO
(If YES, please specify)

DEVELOPMENTAL HISTORY & ACTIVITIES OF DAILY LIVING

FAMILY HISTORY OF MENTAL RETARDATION: YES / NO
(If YES, please specify)

PHYSICAL EXAMINATION

Height: _____ Weight: _____ Head Circumference: _____

Dysmorphic features

Neurological Assessment

Vision _____

Hearing _____

Function _____

CONCLUSION AND RECOMMENDATIONS

Reported by: (Name & Signature) _____

Designation: _____ Hospital / Clinic: _____ Date: _____
(A stamp is preferred)