VORM/FORM: D

ALGEMENE INLIGTING VIR MEDIESE DOELEINDES/GENERAL INFORMATION FOR MEDICAL PURPOSES

AFDELING: A/SECTION A (Inligting van applikant/aansoeker) (Information of applicant)
(Moet deur ouer/familielid voltooi word / Must be completed by parent/relative)

1. Applikant se van/ Surname of applicant: .....

2. Volle voorname van applikant/Full names of applicant: .....

   .....

3. Manlik/Vroulik: .....

   Male/Female: .....

4. Geboortedatum van applikant/ Applicant's date of birth: .....

5. (a) Het applikant enige allergieë? (Spesifiseer) .....
   Is applicant allergic to anything? (Spesify)

   .....

   (b) Beskryf applikant se reaksie op allergieë: .....
   Describe applicants reaction to allergies

   .....

6. Op watter ouderdom het applikant begin/At what age did the applicant start to:

   Sit: .....

   Praat/Speak: .....

   Loop/Walk: .....

7. Was daar enige komplikasies tydens geboorte. / Were there any birth complications?
   .....

   .....

8. Het applikant al enige operasies ondergaan. (Spesifiseer asseblief) / Has the applicant undergone any operations. (Please specify).....

……

9. Menstrueer sy nog in geval van ‘n dame / In the case of a female, does she still menstruate? ……..

10. Watter voorbehoedmiddel gebruik sy tans? / What form of birth control does she presently use?.....

11. Het applikant enige siekte van die brein bv. meningitis gehad. / Has the applicant suffered from any infection of the brain, etc. meningitis:
……

12. Het applikant al enige hoofbeserings opgedoen. / Has the applicant ever sustained head injuries?
……..

13. Kry die applikant ooit chroniese hoofpyn. / Has the applicant ever been troubled by chronic headaches?

……..

14. Was applikant al ooit bewusteloos? Indien wel, hoe lank en wat het dit veroorsaak. / Has the applicant ever been unconscious? If so, for how long, and why?
……

15. Kry die applikant epilepsie?Does the applicant get epilepsy? .....
Indien Ja, verduidelik applikant se reaksie daarop/If yes, please explain applicant’s reaction:.....

.....

16. Selfstandigheid ten opsigte van/Independence regarding:

	Kan sonder hulp Independent	**Benodig hulp Need help**	**Kan glad nie sonder hulp/Totally dependent**
Toilet gebruik/Toilet use			
Eet/Eat			
Slaap/Sleep			
Kleding/Clothing			
Persoonlike higiene/Personal hygiene			

Loop/Walk			
Blaasbeheer/Bladder control			
Bedags/During the day			
Snags/At night			

Voltooi asseblief aanhangsel (A) agteraan vorm. Please complete attachment (A) at back of form.

AFDELING B:
(Moet deur geneesheer/mediese persoon voltooi word. / To be completed by doctor/medical person.)

1. Algemene Ondersoek / General Examination:

   (a) Bloeddruk/Blood pressure:
   ……

   (b) Gewig/Weight:
   ……

   (c) Lengte/Height:
   ……

   (d) Visie/Sight:
   ……

   (e) Gehoor/Hearing:…….
   Het die applikant dikwels las van oorinfeksie gehad? Did the applicant often suffered from ear infection?.....

   (f) Vel/Skin: ……Het applikant enige las van infeksies? / Did the applicant often suffered from skin infection?

   ……

   (g) Beenstelsel en Gewrigte/Skeleton and Joints: …….

   ……

   (h) Bloedsomloopstelsel/Circulatory system: ……

   ……

   (i) Tande/Teeth: ……

   (j) Asemhalingstelsel/Respitory system: ……..

(k) Spysverteringstelsel/Digestive system: ……

(l) Urine toets/Urine test: ……..

(m) Senustelsel/Nervous system: ……

2. Graad van ongeskiktheid vir ope arbeidsmark. / Degree of disability for open labour market:
……

3. Verwagte duur van ongeskiktheid. / Expected duration of disability:
……

4. Toon die applikant enige psigiese afwykings. Indien wel, spesifiseer asseblief. Is die persoon skisofrenies/bipolêr?
Does the applicant show any signs of psychiatric abnormalities? If so, please give details. Any form of bipolar disorder or schizophrenia?

Psigoses/Phychosis: ……

Delusies/Delusions: ……..

Hallusinasies/Hallucinations: ……..

Verstandelike gestremdheid/Mental Disability: ……

Enige ander/Any other: ……

5. Is u bewus van enige ander ernstige siektetoestande waarvoor applikant behandeling ontvang het of nog steeds ontvang. Dit sluit in alle huidige medikasie. Do you know of any other illness that the applicant needed treatment for or still is receiving treatment for? It includes present treatment.

……

……

……

6. In geval van Psigiatriese of Neurologiese behandeling - Gee meer besonderhede.
In case of Psychiatric or Neurological treatment - Please give more details. (**heg asseblief psigiater/sielkundige verslag aan.) (Please attach report from psychiatrist/psychologist)**

……

……

……

……

7. Dra u enige kennis dat die applikant hom/haar al ooit skuldig gemaak het aan: / Do you know whether the applicant has ever misused:

(a) Drankmisbruik/Alcohol:

……

(b) Dwelmmisbruik/Drugs: Gee asseblief volle besonderhede. / Please give details:

……

……

……

NAAM VAN DOKTER/NAME OF DOCTOR:.....

ADRES: ……

……

KONTAKNOMMER/CONTACT NUMBER:.....

PRAKTYKNOMMER/PRACTICE NUMBER:.....

HANDTEKENING/SIGNATURE:.....

DATUM/DATE: .....

Aanhangsel (A) Dames-applikante

As deel van Emmaüs se voorkomende Gesondheidsbeleid is dit vir ons belangrik om die volgende vrywaring van u te verkry. Dit is ook vir ons belangrik dat die gestremde persoon of haar ouer/voog ingelig is oor kontrasepsie.

Hiermee erken ons, …….. , (naam & van)

ouer/voog van …….…… dat ons ingelig is oor die gebruik van

……. as kontrasepsie.

Ons verstaan die werking daarvan en hoekom dit belangrik is dat dit geneem word. Ons besef dat indien die spesifieke middel nie gereeld gebruik word nie, dit kan lei tot swangerskap indien die persoon seksueel aktief is. Ons is bewus daarvan dat daar 'n klein persentasie persone is wat kan swanger raak al gebruik hulle gereeld kontrasepsie. Kontrasepsie bied nie beskerming teen die verkryging van die HIV virus nie. Ons besef as ouers/voog dat dit ons verantwoordelikheid is om ons kind in te lig oor gesonde seksuele gewoontes.

(Merk u keuse met X)
*Ons verkies dat kontrasepsie by Emmaüs hanteer en volledig rekord van gehou word:

JA: …….. NEE: ……

Hiermee bevestig ek ……. (kind/ouer/voog)
dat ek verstaan waaroor genoemde inligting gaan en dat ek nie Emmaüs of betrokke personeel verantwoordelik sal hou ingeval ek gereeld kontrasepsie gebruik en swanger raak nie.

OF

Hiermee bevestig ek …… (kind/ouer/voog)
dat ek op eie verantwoordelikheid nie enige kontrasepsie wil gebruik nie. Ek sal ook nie Emmaüs of betrokke personeel verantwoordelik hou indien ek swanger raak of die HIV virus opdoen nie.

…… ……
HANDTEKENING DATUM

Attachment (A) Female applicants

As part of Emmaüs's health policy we need the following exemption from you. It is furthermore important that the disabled and or parents are fully informed about contraception.

We, …….. (name & surname), parents of

…… acknowledge that we are informed about the use of

……as a form of contraception.

We understand how contraception works and the importance thereof. We realise that, should the contraception not be taken regularly, a sexually active person can become pregnant. We are also aware of the fact that a small percentage of women can get pregnant although on contraception. Contraception also does not prevent the HIV virus. We realise that it is our duty as parents to inform our child/guardian about sexual matters.

(Mark your choice with an X)
*We prefer that Emmaüs handle contraception and keep accurate records:

Yes: _____ No: _____

I, …… child, parent/guardian, hereby acknowledge that
I fully understand the abovementioned information. I will not hold Emmaüs responsible if I become pregnant while on contraception.

OR

I, …… child, parent/guardian, hereby acknowledge
that I do not want to use contraception. I will not hold Emmaüs responsible if I get pregnant or the HIV virus.

…….. ……
SIGNATURE DATE