

**WAITING LIST**

**TO BE COMPLETED BY DOCTOR**



**THE LEWIS W HAMMERSON MEMORIAL HOME  
HAMMERSON HOUSE, 50A THE BISHOP'S AVENUE, N2 0BE  
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**MEDICAL CERTIFICATE**

1. Name of Applicant \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(IN BLOCK LETTERS)

2. Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Can he/she wash, dress and feed self? \_\_\_\_\_

4. Can he/she walk unaided? \_\_\_\_\_

5. Can he/she go up and down stairs? \_\_\_\_\_

6. a) Is there any physical and mental problems or disease at the present time?  
\_\_\_\_\_  
\_\_\_\_\_

b) What is the disability and what physical limitations does it impose?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Is there, or has there been, any incontinence? \_\_\_\_\_

8. Is he/she subject to epileptic fits? \_\_\_\_\_

9. Is he/she known to have required or requires treatment for any mental problems?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Does he/she require any form of nursing? \_\_\_\_\_

11. Has he/she been an in-patient at a hospital? \_\_\_\_\_

If so:

a) Why? \_\_\_\_\_

b) When? \_\_\_\_\_

c) Where? \_\_\_\_\_

12. What –

a) Tablets \_\_\_\_\_

b) Injections \_\_\_\_\_

c) Other Treatment \_\_\_\_\_

– is the applicant having at present?

13. Are there any special dietary requirements? \_\_\_\_\_

\_\_\_\_\_

14. Please add any points not covered by previous questions and the names of any regular consultants that the applicant sees?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Postcode \_\_\_\_\_

**Practice Stamp**

