GOVERNMENT OF THE COOK ISLANDS
MINISTRY OF INTERNAL AFFAIRS
P O Box 98, Rarotonga, Cook Islands * Tel: (682) 29-370 * Fax: (682) 23-608 * E-mail: welfare@intaff.gov.ck

CAREGIVERS MEDICAL SUPPORT FORM

Supported Persons Personal Details (the person who will be receiving care & attention)

First Name: _____Surname or Family Name: _____
Are you known by any other name NO YES (please give details below)
Other name/s: _____
_____

Date of Birth:_____ Gender: ____ Village:_____ Island: _____

Contact Details Telephone/ mble: _____ Fax: _____
Email: _____

Carers Personal Details (the person who will be providing care & attention to a supported Person)

First Name: _____Surname or Family Name: _____
Are you known by any other name NO YES (please give details below)
Other name/s: _____
_____

Date of Birth:_____ Gender: ____ Village:_____ Island: _____

Contact Details Telephone/ mble: _____ Fax: _____
Email: _____

Medical Details: *(this section will be filled out by a medical practioner)*

Who do you consider best placed to provide this information?

☐ Yourself ☐Second Opinion

Other :

Are you the Supported Persons usual medical practioner?
☐ No ☐ Yes

When did you last see the supported person? (Including today)
Date last seen: ☐ Never

When is the next scheduled appointment? _____

Please indicate what information this assessment is based on:

_____
_____
_____

What are the supported person's main diagnoses? (Please list the diagnoses in order of their impact starting with the most significant.)

_____
_____
_____
_____
_____

Indicate the main factors that determine the supported person's need for care and attention:

TYPE:	**DESCRIPTION**
PHYSIOLOGICAL/ HEALTH RELATED	☐ **Physical limitations** ☐ **Psychiatric/Psychological condition** ☐**Cognitive/neurological condition** ☐**Sensory Impairment** ☐**Undergoing current treatment** ☐**frequent hospitalization/treatment demands** ☐**Terminal illness** ☐**High levels of Physical support** ☐ **mobility restrictions** ☐ **Chronic pain**
SAFETY	☐ **Respiratory Support** ☐ **Risk to life/ life threatening condition** ☐**Fall risk** ☐**Home safety/security** ☐ **Wandering**
PERSONAL CARE/ HOUSEHOLD MANAGEMENT	☐ **Hygiene/grooming – including dressing & showering or bathing** ☐ **Toileting/continence** ☐**Eating/Drinking** ☐**Medication** ☐**Meal Preparation** ☐**Shopping** ☐**Housework/Laundry** ☐**Finances**

MEMORY, COGNITION AND BEHAVIOUR OTHER (Please Specifiy):	**☐ Memory Loss** **☐ Poor orientation to surroundings** **☐Delusions/hallucinations** **☐Mood/anxiety** **☐Inappropriate social behavior** **☐Limited insight**

Please comment on how these factors impact on the supported person's need for care and attention:

_____
_____
_____
_____

Does the supported person require full time care and attention?

☐NO ☐YES

Is the need for care and attention time limited or permanent?

☐ Time limited (Please specify the expected duration)

_____
_____

☐ Permanent

Medical Practioners / Nurse Practioners :

Name: _____ Family name or surname: _____
Island: _____ Village: _____

Contact Details:
Telephone/mble:_____ Fax:_____ Email:_____
Post Address:_____

Medical /Nurse Practioners Signature: _____

Date certificate completed: _____