# Section III:

# To be completed by a Medical Doctor, i.e. General Practitioner or Medical Specialist

This section comprises three pages and should take about 10 minutes to complete.

# For children with sensory (e.g. vision, hearing) concerns, please approach a medical specialist for help with this section. A list of such specialists can be found on the MOH Specialists Accreditation Board website ([https://www.healthprofessionals.gov.sg/sab](http://www.healthprofessionals.gov.sg/sab)).

# For all other children, please approach a Medical Specialist or a General Practitioner (e.g. family doctor) for help with this section.

# MEDICAL REPORT

# To the Doctor-in-charge:

This report is a mandatory section of the Special Education (SPED) School Application Form to be completed by a medical professional. The patient has been assessed to be eligible for placement in a SPED school in view of his/her special educational needs. Kindly assist the patient in completing this medical report to facilitate his/her application to a SPED school. Please attach all the relevant reports that were used as the basis for completion of this section. Thank you.

|  |
| --- |
| **1) Child’s particulars** |
| **Full name** |  |
| **BC/NRIC no.** |  | **Gender** |  |
| **Date of birth****(dd/mm/yyyy)** |  | **Age** |  |
| **2) Diagnostic information & Medical background**  |
| **Diagnosis relevant to referral:** 🞏 Autism Spectrum Disorder 🞏 Intellectual Disability  🞏 Visual Impairment 🞏 Hearing Loss 🞏 Multiple Disabilities 🞏 Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Description of Diagnosis:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Onset / Date of diagnosis**(delete where applicable) |  |
| **Cause of condition** | 🞏 Unknown 🞏 Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Other diagnoses / medical conditions:**(e.g. epilepsy, psychiatric conditions) |
| **Onset / Date of diagnosis**(delete where applicable) |  |
| **Cause of condition** | 🞏 Unknown 🞏 Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Is the child currently on medication?**  |

|  |  |  |  |
| --- | --- | --- | --- |
| 🞏 | Yes |  🞏 | No |

If yes, please specify schedule of administration & possible consequences if not medicated: |
| **Is the child having any side-effects from medication?**  |

|  |  |  |  |
| --- | --- | --- | --- |
|  🞏 | Yes |  🞏 | No |

If yes, please specify: |
| **Does the child have G6PD Deficiency?**  |

|  |  |  |  |
| --- | --- | --- | --- |
|  🞏 | Yes |  🞏 | No |

 |
| **Does the child have any allergies?**  |

|  |  |  |  |
| --- | --- | --- | --- |
|  🞏 | Yes |  🞏 | No |

If yes, please specify: |
| **Does the child have recurring medical condition(s) (e.g., epilepsy, brain related injury/condition, physical impairment, etc)?**  |

|  |  |  |  |
| --- | --- | --- | --- |
|  🞏 | Yes |  🞏 | No |

If yes, please specify: |
| **3) Birth history and developmental milestones** |
|  |
| **4) physical examination** |
| **Head circumference** | 🞏 Normal 🞏 Microcephaly 🞏 Macrocephaly |
| **Dysmorphic features****(if any)** |  |
| **Is there a medical condition for the following?** |
| **Heart** |  |
| **Lungs** |  |
| **Musculoskeletal system** |  |
| **Hearing:**Has the child undergone hearing screening (e.g.Universal Neonatal Hearing Screening (UNHS))? |

|  |  |  |  |
| --- | --- | --- | --- |
|  🞏 | Yes  |  🞏 | No  |

If yes, please specify date:If the child failed the UNHS, was the child sent for further assessments?If yes, please specify date & outcome: |
| Right ear drum |  | Left ear drum |  |
| Does the child have hearing loss? |

|  |  |  |  |
| --- | --- | --- | --- |
|  🞏 | Yes  |  🞏 | No  |

**If yes, please include a copy of the audiogram.** Please specify details of1. Degree of hearing loss:
2. Cause of hearing loss:
3. Hearing devices used and Year of fitting:
4. Year of cochlear implantation (if applicable):
 |
| **Vision:**Does the child have visual impairment?  |

|  |  |  |  |
| --- | --- | --- | --- |
|  🞏 | Yes  |  🞏 | No  |

If yes, please specify details: |
| Right eye |  6 /  | Left eye |  6 /  |
| Squint? |

|  |  |  |  |
| --- | --- | --- | --- |
|  🞏 | Yes  |  🞏 | No  |

 | Astigmatism?  |

|  |  |  |  |
| --- | --- | --- | --- |
|  🞏 | Yes  |  🞏 | No  |

 |
| Does the child have any physiological and/or medical conditions that schools have to take note of (e.g. hydrotherapy, horse riding, physical education, swimming)? Please provide details/reasons. |
|  |
| **5) Any other medical precautions** |
|  |
| **6) Remarks / recommendations / prognosis** |
|  |

|  |
| --- |
| **Completed by:** |
| **Doctor’s name** |  | **Signature** |  |
| **Contact no.** |  | **Date** |  |
| **Hospital / Clinic****(Official stamp)** |  |