# 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 who is familiar with the child (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 of   1. 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)** |  | | |