Malta Camp USA
July 9-13, 2023

EVALUATION OF MEDICAL CONDITION AND
MEDICAL/NURSING CARE REQUIREMENTS OF PROSPECTIVE PARTICIPANT WITH DISABILITY

IT IS NECESSARY TO ANSWER **ALL** QUESTIONS

GENERAL GUEST INFORMATION:

Name: Date of Birth:

Address:

City: ST: Zip:

Preferred Phone Number: Email Address:

Physician's Evaluation

Please return this **directly** to the Order of Malta, American Association Office.

For this patient to be considered for the Malta Camp USA 2023, all questions must be answered and signed off by his/her physician.

1. Primary disability: _____

_____

_____

2. Other relevant medical diagnoses: _____

_____

_____

_____

3. Prior surgeries: _____

_____

_____

_____

4. Have there been any hospitalizations in the past 6 months? If yes, please provide a very brief explanation of the reason for the admission? _____

_____

_____

5. Are there any planned procedures or hospitalizations planned in the next 3 months? If so, what procedure or for what reason?_____

_____

Does your patient wish to be: ❑ DNR
❑ "Everything Done"

6. Has the patient completed advanced directives, a living will or other health care instructions?
❑ Yes ❑ No If yes, please provide.

7. The patient must be physically able to travel to New York State, and participate in a 5-day, 4-night camp program. Please keep in mind the possible stress and strain associated with travel, changes in

time zone, and diet

Is this patient medically stable to travel to the Camp? ❑ Yes ❑ No

Will this patient require the use of portable oxygen or special equipment while traveling or at the camp?
❑ Yes ❑ No If yes, please explain: _____

_____

Will this patient require the use of any electrical device, for example electric wheelchair, CPAP?
❑ Yes ❑ No

If yes, please explain: _____

_____

8. What, if any, complications might this patient experience with travel

_____

_____

_____

9. How often do you see this patient? _____

10. Does the patient smoke? ❑ Yes ❑ No If yes, # of packs per day _____

11. Is the patient currently undergoing any treatment for his/her disability? ❑ Yes ❑ No
If yes, what is the nature of the treatment and do you expect to complete it in the near future? If so, when? _____

_____

_____

12. How would you describe the patient's ability to cope with their disability (mentally, as well as physically) _____

_____

_____

13. Medications: Please list all medications of patient, including dosages and schedule

Medication	Dosage	Schedule

14. Please list all known allergies to medications and foods:

_____

_____

15. Please provide any additional comments or information that would be helpful for the selection committee: _____

_____

_____

Detailed Review of Systems

1. Cardiovascular: Problem: ❑ Yes ❑ No

If yes, specify:

❑ Chest Pain

❑ Palpitations

❑ Shortness of Breath

❑ Swelling of lower extremities

❑ Blood Pressure

❑ Other: _____

❑ Stroke

Comments: _____

_____

2. Respiratory: Problem: ❑ Yes ❑ No

If yes, specify:

❑ Cough ❑ Abnormal sputum

❑ Shortness of Breath ❑ Other: _____

Comments: _____

_____

3. Speech Impediment: Problem: ❑ Yes ❑ No

If yes, describe: _____

Does this individual speak English: ❑ Yes ❑ No

4. Hearing: Problem: ❑ Yes ❑ No

If yes, describe: _____

Hearing Aid: ❑ Yes ❑ No

5. Vision: Problem: ❑ Yes ❑ No

If yes, describe: _____

6. Gastrointestinal: Problem: ❑ Yes ❑ No

If yes, specify:

❑ Pain ❑ Nausea ❑ Vomiting ❑ Ileostomy ❑ Colostomy

Comments: _____

_____

7. Bowel: Problem: ❑ Yes ❑ No

❑ If yes, specify: _____

_____

❑ Constipation ❑Diarrhea

Comments: _____

Incontinence: ❑ Frequent ❑Occasional

Comments: _____

Level of care: ❑ Self ❑ Physical Assistance

Specify: _____

8. Urinary: Problem: ❑ Yes ❑ No

If yes: ❑ Frequency ❑ Pain

Specify: _____

Incontinence: ❑ Frequent ❑ Occasional ❑Bedwetting

Comments: _____

Assistive devices: ❑ Catheter ❑ External ❑ Indwelling ❑ Other: _____

Comments: _____

Level of care: ❑ Self ❑ Physical Assistance

Specify: _____

9. Nutrition: Problem: ❑ Yes ❑ No

If yes, describe: _____

Level of nutritional care needed: _____

Special Diet: ❑ Yes ❑ No

If yes, specify: _____

Needs to be fed: ❑ Yes ❑ No

Comments: _____

10. Neuromuscular Problem: Check all applicable items:

❑ Ambulatory

❑ Ambulatory with limitation

❑ Non-ambulatory

❑ Amputation: ❑Yes ❑ No

If yes, describe: _____

Paralysis: ❑ Yes ❑ No If yes, describe: _____

Seizures: ❑ Yes ❑ No If yes, Type: _____ Frequency _____

Significant limitation of motion: ❑ Yes ❑ No If yes, describe: _____

_____

Supportive devices: ❑ Yes ❑ No

If yes, type: ❑ Cast ❑ Bandage ❑ Brace ❑ Other

Comments: _____

11. Hygiene/Grooming:

Level of care needed: _____

Bathing: ❑ Self ❑ Assistance - ❑Total ❑Partial

Dressing: ❑ Self ❑ Assistance - ❑Total ❑Partial

Hair: ❑ Self ❑ Assistance - ❑Total ❑Partial

12. Psychiatric: Problem: ❑ Yes ❑ No

If yes, specify: _____

_____

❑ Anxiety: _____

❑ Depression: _____

❑ Mood Swings: _____

❑ Irritability: _____

13. Skin: Problem: ❑ Yes ❑ No

Pressure sores: ❑ Yes ❑ No

Describe: _____

_____

14. Mobility: Does this individual use his/her own wheelchair? ❑ Yes ❑ No

If yes, please specify: ❑ Manual ❑ Battery Operated

Width: _____ Height: _____ Depth: _____ Weight: _____

Does this individual have difficulty walking long distances? ❑ Yes ❑ No

Physical Examination

Height: _____ Weight: _____ Blood Pressure _____

Head: _____

_____

Ears: _____

_____

Eyes: _____

_____

Nose: _____

_____

Throat: _____

_____

Neck: _____

_____

Lungs: _____

_____

Heart: _____

_____

Abdomen: _____

_____

Genitalia: _____

_____

Rectal: _____

_____

Skin: _____

_____

Extremities: _____

_____

Diagnosis: _____

_____

_____

Specific Medical Care Requirements: _____

_____

General Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

IT IS NECESSARY TO ANSWER ALL THE QUESTIONS ABOVE

REMINDER: For this patient to be considered for Malta Camp USA, all questions **must** be answered and signed off by his/her physician.

***APPLICATION CANNOT BE PROCESSED WITHOUT THE SIGNATURE OF A PHYSICIAN**

Physician's Signature:* Date:

Print Physician's Name:

Physician's Address:

Office Number: Fax Number:

Email Address: