

(To be completed by Medical Doctor ONLY) ANNEX B

DOCTOR'S ASSESSMENT REPORT FOR SPECIAL NEEDS SAVINGS SCHEME (SNSS)

Particulars of Person with Special Needs (PSNs)	
Name :	_____ NRIC : _____
DOB :	_____ Age : _____ Gender : <input type="checkbox"/> Male <input type="checkbox"/> Female
Type of Disability	
<input type="checkbox"/> Physical (E.g., Paralysis, immobility or loss of limbs resulting from stroke, neurological-related conditions, muscular degenerative diseases or amputations, etc)	
<input type="checkbox"/> Intellectual	
<input type="checkbox"/> Developmental (E.g., Autism Spectrum Disorder, Global Developmental Disorder, etc)	
<input type="checkbox"/> Sensory (Visual & Hearing Impairment)	
<input type="checkbox"/> Multiple Disabilities	
<input type="checkbox"/> Others (Please specify):	
Functional Assessment - Activities of Daily Living (ADL)	
Washing Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means.	<input type="checkbox"/> No help is needed <input type="checkbox"/> Needs help / supervision most of the time <i>Comments:</i>
Dressing Ability to put on, take off, secure and unfasten all garments (upper and lower) and, any braces, artificial limbs or other surgical appliances.	<input type="checkbox"/> No help is needed <input type="checkbox"/> Needs help / supervision most of the time <i>Comments:</i>
Feeding Ability to feed oneself after food has been prepared and made available.	<input type="checkbox"/> No help is needed <input type="checkbox"/> Needs help / supervision most of the time <i>Comments:</i>
Toileting Ability to use the toilet or manage bowel and bladder function through the use of protective undergarments or appropriate surgical appliances.	<input type="checkbox"/> No help is needed <input type="checkbox"/> Needs help / supervision most of the time <i>Comments:</i>
Transferring Ability to move from (a lying position on the) bed to an upright chair or wheelchair, and vice versa.	<input type="checkbox"/> No help is needed <input type="checkbox"/> Needs help / supervision most of the time <i>Comments:</i>
Mobility Ability to move indoors from room to room on level surfaces.	<input type="checkbox"/> No help is needed <input type="checkbox"/> Needs help / supervision most of the time <i>Comments:</i>
Confirmation of Assessment	
Does the PSNs requires assistance in at least one (1) ADL?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the disability permanent?	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____
Name & Signature of Doctor	Stamp of Clinic / Hospital
	Date of Assessment

**Assessing Doctor must sign against any amendment made on this form. Otherwise, it will be deemed as 'Incomplete'.