**Please note: To be completed by the attending Health professional at their closest Public Health Facility or the facility regularly attend by the deceased.**

Health

**MEDICAL SUMMARY OF CLIENT AT FACILITY OUTSIDE DOH**

|  |  |
| --- | --- |
| Name: | (place sticker here if available) |
| DOB:  | Folder Number: |
| Diagnoses: |  |
| Clinical History: |  |
| Physical condition: |  |
| Results of Relevant Investigations: |  |
| Medication & Dosages: |  |
| Completed by: |  |
| Date: |  |