



Medical Screening Form

All parts of this form are to be completed by a registered doctor of the country of residence of the trainee.

Part 1 Personal Particulars of Trainee

Name: _____ Passport No: _____ Sex: Male/Female Height: _____ cm
 Course Attending: _____ Date of Birth: _____ Citizenship: _____ Weight: _____ kg

Part 2 Medical History (filled in together with medical practitioner)

DRUG ALLERGY: _____

	YES	NO	If yes, give details
1. Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	
2. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
3. Chronic Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
4. Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	
5. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
6. Pregnant (currently)	<input type="checkbox"/>	<input type="checkbox"/>	
6. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
7. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
8. Malaria	<input type="checkbox"/>	<input type="checkbox"/>	
9. Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
10. Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	
11. Heat Injury	<input type="checkbox"/>	<input type="checkbox"/>	
12. Others	<input type="checkbox"/>	<input type="checkbox"/>	

I declare that the information given above is true and correct. I hereby give my consent for a copy of this medical report after it is completed by the examining doctor to be released to the Singapore Civil Defence Force.

Signature of Trainee

Date

Part III (Please tick the appropriate boxes if abnormal, and give brief details if abnormal)

Clinical Examination	Abnormal	Tests	Abnormal
1. Cardiovascular System		1. Chest X-ray	<input type="checkbox"/>
a. Blood Pressure	<input type="checkbox"/>	2. ECG	<input type="checkbox"/>
Systolic:		3. Urine Dipstick	<input type="checkbox"/>
Diastolic:		a. Albumin	
b. Heart Disease	<input type="checkbox"/>	b. Sugar	
c. Severe varicose veins	<input type="checkbox"/>	4. Full Blood Count: Hb: _____ Plt: _____ /L TW: _____	<input type="checkbox"/>
2. Anaemia (clinically anaemic)	<input type="checkbox"/>	5. Fasting Glucose: _____	<input type="checkbox"/>
3. Respiratory System	<input type="checkbox"/>	6. Fasting lipids*:	<input type="checkbox"/>
		T Chol : _____ HDL : _____ LDL : _____ TG: _____	
4. Abdomen		7. Creatinine*:	<input type="checkbox"/>
a. Hernia	<input type="checkbox"/>	8. Treadmill test (TMX)*#: <u>positive/negative</u>	<input type="checkbox"/>
b. Hepatomegaly	<input type="checkbox"/>	9. Vision (should be at least 6/12 in both eyes with/without glasses)	
c. Splenomegaly	<input type="checkbox"/>	a. Visual Acuity	
d. Genito-urinary System	<input type="checkbox"/>	i. Right eye: 20/ Corrected to: 20/	<input type="checkbox"/>
e. Lymph nodes	<input type="checkbox"/>	ii. Left eye: 20/ Corrected to: 20/	<input type="checkbox"/>
5. Skin – Chronic Disease (e.g. leprosy, widespread eczema, psoriasis, etc)	<input type="checkbox"/>	b. Any organic eye disease, e.g. Trachoma	<input type="checkbox"/>
6. Musculoskeletal/Neurological		10. Hearing – hear ordinary conversations at 2m	<input type="checkbox"/>
a. Significant limb amputation/deformity	<input type="checkbox"/>	11. Other investigations if done: _____	<input type="checkbox"/>
b. Limb movement and co-ordination	<input type="checkbox"/>		
c. Spinal deformity	<input type="checkbox"/>		
d. Other abnormalities/orthopaedic history	<input type="checkbox"/>		
7. Endocrine disorder, e.g. Thyrotoxicosis	<input type="checkbox"/>		
8. Mental state	<input type="checkbox"/>		

Part IV (please tick in the box)

Clinical examination/tests required above are normal except those test results indicated "abnormal" (if any) in Part III.

Part V Certification from Doctor (any amendments must be endorsed by the Doctor who completes this report)

I certify that I have examined the above-named patient and found that this person is ***FIT/UNFIT** for the course stated above.

Remarks: _____

Name of Doctor: _____

Signature of Doctor: _____

Clinic Address: _____

Date: _____

Tel: _____

* For the Basic CBRE and Fire and Rescue Courses for CERT, the investigations (Fasting lipids, TMX and Creatinine) are not required as part of routine medical screening unless deemed clinically indicated by the doctor.

Indication for Stress ECG/Treadmill Test (TMX) or an equivalent test (Stress Echo or MIBI scan)

For patients with no Cardiovascular Risk Factors (CVRFs) or 1 CVRF, a valid negative TMX in the last 12 months is required for participants 40 years old or older.

For patients with 2 CVRFs, a valid negative TMX in the last 12 months is required for participants 35 years old or older.

For patients with 3 or more CVRFs, a valid negative TMX in the last 12 months is required for participants 25 years old or older.

If TMX is not available, a stress echo or MIBI scan is acceptable as an alternative.

For patients with positive TMXs, they should consult their cardiologist to do further investigation (Stress Echo or MIBI scan). Subsequently, a letter from the cardiologist declaring the patient fit for rigorous exercise should be attached to the application form, together with the additional investigation (Stress Echo or MIBI scan) results.

CVRFs

- a. Currently smoking
- b. First degree relative with Coronary Heart Disease (male relative <55 years, female relative <65 years)
- c. Indian ethnicity
- d. Excessive alcohol consumption (>3 standard drinks or >45g alcohol per day)
- e. Sedentary lifestyle (exercise <2 times per week)
- f. Blood pressure $\geq 140/90$ mmHg or hypertension on treatment
- g. Obesity (BMI ≥ 30)
- h. Dyslipidaemia (total cholesterol > 6.2mmol/L (240mg/dL), or HDL < 0.9mmol/L (35mg/dL), or LDL > 4.1mmol/L (160mg/dL)
- i. Diabetes Mellitus (N.B. This is considered as 2 coronary risk factors)

Adapted from SCDF Medical Department Directive No: 01 / 2012 - IPPT Medical Screening Programme