REPUBLIC OF CYPRUS
DEPUTY MINISTRY OF SOCIAL WELFARE

DEPARTMENT FOR SOCIAL INCLUSION OF PERSONS WITH DISABILITIES
1430 NICOSIA

PERSONAL DOCTOR REFERENCE FORM FOR THE DISABILITY ASSESSMENT CENTER

(This form must be completed by the personal doctor of the person who will undergo the assessment procedures. If the person has more than one personal doctors who are related to the person's disability, this form must be completed by them also. If the person doesn't have a personal doctor, this document can be completed by a doctor withholding a specialty related to the person's disability.

Date: ……

Person's Details

Name and Surname

Identitification No | Date of Birth

Doctor's Details

Name and Surname

Specialty | Medical Registry Number

Employed at Public Service ☐ Private ☐ Address

Telephone | Fax | E-mail

Date of first evaluation by the doctor __/___/_____

MEDICAL DIAGNOSIS of current medical issues

(Please complete ICD-10 codes if possible. Declare first the issue with the biggest severity and proceed to the less severe ones.)

_____ Onset since: _____ ICD Code: _____

_____ Onset since: _____ ICD Code _____

_____ Onset since: _____ ICD Code _____

Medication	Dosage	Onset since

RESULTS FROM CLINICAL EVALUATIONS :

Type of evaluation	Date	Results

SHORT MEDICAL HISTORY:

(Please, provide a brief history of the individual's health problems, including those for which the person was recently hospitalized in a clinic / hospital. Indicate the chronological series of the person's diseases, regardless if they fall in your specialty or not and the history of the person's hospitalizations. Your description should also include data on the hospitalization of the individual and the state of his/her health, as well as his/her monitoring as an outpatient.)

I confirm the accuracy of the information given above that will be submitted to the Disability Assessment Center of the Department for Social Inclusion of Persons with Disabilities.

Signature, full name and stamp of doctor