SNTC Special Needs Trust Co.
an SG Enable company

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(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** : ☐ Male ☐ Female

Type of Disability

❑ **Physical**
(E.g., Paralysis, immobility or loss of limbs resulting from stroke, neurological-related conditions, muscular degenerative diseases or amputations, etc)

❑ **Intellectual**

❑ **Developmental**
(E.g., Autism Spectrum Disorder, Global Developmental Disorder, etc)

❑ **Sensory**
(Visual & Hearing Impairment)

❑ **Multiple Disabilities**

❑ **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.	❑ No help is needed ❑ Needs help / supervision most of the time *Comments:*
Dressing Ability to put on, take off, secure and unfasten all garments (upper and lower) and, any braces, artificial limbs or other surgical appliances.	❑ No help is needed ❑ Needs help / supervision most of the time *Comments:*
Feeding Ability to feed oneself after food has been prepared and made available.	❑ No help is needed ❑ Needs help / supervision most of the time *Comments:*
Toileting Ability to use the toilet or manage bowel and bladder function through the use of protective undergarments or appropriate surgical appliances.	❑ No help is needed ❑ Needs help / supervision most of the time *Comments:*
Transferring Ability to move from (a lying position on the) bed to an upright chair or wheelchair, and vice versa.	❑ No help is needed ❑ Needs help / supervision most of the time *Comments:*
Mobility Ability to move indoors from room to room on level surfaces.	❑ No help is needed ❑ Needs help / supervision most of the time *Comments:*

Confirmation of Assessment

Does the PSNs requires assistance in at least one (1) ADL? ❑ Yes ❑ No

Is the disability permanent? ❑ Yes ❑ 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'.*