REPUBLIC OF KENYA

MINISTRY OF HEALTH

Ref: MOH/276F

ASSESSMENT FOR MAXILLOFACIAL DISABILITIES

Name of Health Facility:		Date:	DD	MM	YYYY

Applicant Information for the purpose of reporting on Disability Assessment:

Name:		ID No.		Gender:	
Date of Birth: Age:	DD / MM / YYYY	Occupation:		Phone No.	
County:		Sub-County:		Marital Status:	

Next of Kin Details:

Name:		Relation:		Phone No.	

Assembled Medical Team details:

MEMBERS	NAME	REG. NO.	SIGNATURE	Health Facility Official Stamp
Chairperson				
Member				
Member				
Member				

(***I understand that giving false information is punishable by the laws of Kenya)***

Note: the committee should have a minimum of three Members

SUMMARY FINDINGS

Medical History

Dental History

Dental Assessment

CONCLUSION

TEMPORARY ☐ PERMANENT ☐

RECOMMENDED ASSISTIVE PRODUCT(S)..

OTHER SERVICES REQUIRED..

VERIFIED BY THE COUNTY DIRECTOR OF HEALTH

Name ....

Date ....

Signature..

COUNTY DIRECTOR OF HEALTH OFFICIAL STAMP