

## Physician's Report

Name (First, Middle, Last)				Telephone No. (     )	
Birth Date (MM/DD/YY)	Sex	Marital Status	Medicare No.	Medicaid No.	
Address			City	State	Zip Code
Other Health Insurance (Company Name)			Policy Holder		Policy No.
Worker's Name			Worker's Office Address		Telephone No. (     )

### Consent for Physician's Release of Information

I give my permission to Dr. \_\_\_\_\_ to release medical information and other relevant reports about me to the Department of Human Services for the purpose of determining my eligibility and establishing a plan of care and services for me in the Department's \_\_\_\_\_ program. I understand that this information will be treated confidentially, and a copy of this report may be furnished to an agency providing services to me under an agreement or contract with the Department of Human Services.

Client's Signature	Date
Parent or Guardian's Signature	Date
Witness	Address
	Date

**Note: This consent is valid for no more than 60 days from the date signed.**

**I. Statement of Client's Chief Complaints** \_\_\_\_\_

**II. Pertinent Findings**

A. Physical Examination:	Height	Weight	Blood Pressure
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Person has findings related to:	Yes	No	Unk	Findings	Needs Further Evaluation?	Yes	No
1. HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>
2. Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>
3. Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>
4. Dentition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>
5. Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>
6. Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>
7. Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>
8. Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>
9. Dermatologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>
10. Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>
11. Orientation and thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>
12. Affect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>
13. Nutrition/hydration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>

- B. Laboratory: (General blood test, urinalysis, etc. done) \_\_\_\_\_  
 \_\_\_\_\_
- C. T.B. status (must be re-evaluated each 3 years) \_\_\_\_\_
- D. Other communicable diseases: (If person has such a contagious disease, please explain and give recommendations):  
 \_\_\_\_\_  
 \_\_\_\_\_
- E. Immunizations:  
 1. Diphtheria \_\_\_\_\_ 2. Tetanus \_\_\_\_\_ 3. Polio \_\_\_\_\_

III. Diagnoses and Prognoses: \_\_\_\_\_  
 \_\_\_\_\_

IV. Orders and Recommendations (specific health care needs, treatments, medications, diet, and other special instructions):  
 \_\_\_\_\_  
 \_\_\_\_\_

Duration of service: \_\_\_\_\_

**V. Physician's Certification**

I find this person to be free of clinical evidence of communicable disease and I believe the statement checked below indicates the optimal arrangement for this person.

- This person can live independently and from there receive any services needed.
- This person needs minimal supervision, can live semi-independently, and has needs that can be met in a supervised apartment program.<sup>1</sup>
- This person is essentially capable of physical self-care and has needs that can be met in a certified family-life home.<sup>2</sup>
- This person needs care provided in a licensed residential care facility,<sup>3</sup> but does not need nursing services.
- This person needs health care services supervised by a registered nurse and has health care needs which can be met in the person's own home with in-home health-related care services.<sup>4</sup>
- Other. This person needs the following living arrangement and services: \_\_\_\_\_

Physician's Signature	Date
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<sup>1</sup> A "supervised apartment program" is a program in which persons live in an apartment selected or approved by a provider agency, and are monitored, assisted, taught, counseled and supervised by a provider representative who either lives in the same quarters or is nearby and available to the persons at all times.

<sup>2</sup> A "family-life home" is a private house.

<sup>3</sup> "Residential care facility" means an institution providing accommodation, board, personal assistance, and other essential daily living activities for three or more persons not related to the administrator or owner, who by reason of illness, disease, or physical or mental infirmity are unable to sufficiently or properly care for themselves but who do not require the services of a registered or licensed nurse except on an emergency basis.

<sup>4</sup> "In-home health-related care" is a program of health care provided to persons in their own homes because they are unable to care for themselves adequately. The services needed must be certified by a physician and supervised by a registered nurse.