

PHYSICIANS CONFIDENTIAL REPORT

Recipient/Payee, Relationship, Address	Name of Patient		
	I.D./Social Security No.	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Admission Date	Eligibility Date	Local Office

Name, Address and Specialty of Examining Physician

1. To the Physician: The individual named above is an applicant for or recipient of assistance. Medical findings which you are asked to report on this form are used to determine eligibility for assistance and to plan for medical care and other services. It is important that your report be specific enough to indicate the kind and extent of disability and the treatment and services required. Attach additional pertinent information including hospital admission/discharge summaries, lab reports, consultative reports/letters, psych. reports and testing, etc.

2 Reason for Referral

	Name - Title/Position	Date
3. Diagnosis (Related to present medical condition):	Date of Onset	Anticipated Duration
Primary		
Secondary		
1.		
2.		
3.		

4. Prognosis, Include Rehabilitation Potential:

5. History of Present Illness - Current Medical Symptoms/Conditions (Include pertinent past medical history)

6. Specific Physical Findings (Include pertinent positive and negative findings)

Height _____ Weight _____ Pulse _____ Blood Pressure _____

- A. Vision and Hearing
- B. Respiratory
- C. Gastro-Intestinal
- D. Genito-Urinary
- E. Cardio-Vascular
- F. Musculo-Skeletal
- G. Neurological*

*(Findings must be documented if primary diagnosis is Dementia, Alzheimers or related condition)

7. Mental Findings: Alert Cooperative Psycho-Neurosis Psychosis Other

Is the individual competent to handle his/her own affairs? Yes No Questionable

A. Mental Status:

B. Psychological Test Results:

8. Pertinent Lab Findings: E.G., Hematology, Chemistry, EKG, X-Ray, EEG and other reports that substantiate condition.
(Attach reports)

9. Diet (Results, if applicable):

10. Drugs Prescribed with Dosage and Frequency (Results, if applicable)

11. Recommended Therapy or Treatment Program or Regimen with Expected Duration:

12. Describe any Physical/Mental Conditions which would restrict work or training activities.

A. Temporary Condition(s):

B. Permanent Condition(s):

13. Describe as fully as possible: Attach additional sheets as necessary

A. Limitations in activities of daily living:

B. Limitations in ability to work:

C. Specific restrictions of physical activity (Lifting, sitting, walking, standing, etc.)

14. If, in your professional judgement, this patient's physical and/or mental ability has been impaired or has deteriorated to the degree that he/she cannot be expected to function independently, please indicate below the type/level of service/care required. This will assist the County Caseworker in determining eligibility and making payment for the client.

- Home Health Aide/Personal Care Aide Services
- Home Health Nursing Services
- Alternate Living Arrangement: Residential Care Facility, Adult Foster Home or Domiciliary Facility
- Nursing Facility Services (were needed at the time of admission and continue to be needed)
- Swing-bed services (in rural hospitals)
- ICF/MR Services
- Other (Please specify): _____

List all consultants and their specialties _____

How long has patient been under your care? _____

Date you last examined patient _____

Do you expect to continue treatment? _____

15. Any Other Comments: