REQUEST FOR MEDICAL INFORMATION

Applicant's Name: _____SS #: _____Medicare #: _____

ALLERGIES_____

A. Primary Diagnosis: (ICD 9 code)_____**Secondary (ICD 9 code)**_____

Other_____

B. Medications:(Specify dosage, frequency, and route)

1. _____ **2.** _____ **3.** _____

4. _____ **5.** _____ **6.** _____

7. _____ **8.** _____ **9.** _____

C. Recent Hospitalizations: (include psychiatric)_____

D. Mental Status/Behavior: Circle appropriate response and indicate frequency 1-seldom 2-frequent 3-always, if applicable

Oriented ___Yes (1, 2, 3)___No **Forgetful** ___Yes (1, 2, 3) ___No **Depressed** ___Yes (1, 2, 3) ___No **Confused** ___Yes (1, 2, 3) __No

Wanders ___Yes (1, 2, 3)___No **Hostile** ___Yes (1, 2, 3) ___No **Combative**___Yes (1, 2, 3) ___No

E. Activities of Daily Living: (Select appropriate choice) ___Verbal ___Non-Verbal ___Comatose

	SELF	ASSIST	TOTAL		
Eating	_____	_____	_____	___Impaired vision ___Glasses	___Impaired Hearing ___Hearing Aid
Bathing	_____	_____	_____	___Incontinent Bowel _____	___Incontinence Bladder _____
Personal	_____	_____	_____	___Urinary Catheter_____	
Oral Hygiene	_____	_____	_____	___Ostomy care_____	
Ambulation	_____	_____	_____	___Dentures ___Upper___ Lower ___Partial	

DME _____

F. SPECIAL CARE/PROCEDURES: (check appropriate choice - when appropriate give type, frequency, size, stage and site)

___Glucose Monitoring_____ **___Diet/Tube Feeding**_____
___Restraints _____ **___Dialysis**_____
___MRSA/VRE-_____ **___Seizures** _____ **___Suctioning**_____
___Rehab _____ **___ MRSA/VRE-**_____
___Decubitus_____
___Other_____

G. PHYSICAL EXAMINATION: Height_____**Weight**_____**Pulse**_____**Resp**_____**Temp**_____**B/P**_____

Lab Results: HCT_____**HGB**_____**U/A**_____ **Radiology**_____
General_____ **Head and CNS**_____
Mouth and EENT_____ **Chest**_____
Heart and Circulation_____ **Abdomen**_____
Genitalia_____**Extremities**_____
Skin_____ **Other**_____

H. Immunizations: Last PPD _____**Last Flu Vaccine** _____**Last Pneumonia Vaccine** _____

MD/Licensed Nurse Signature_____**Date**_____