Office of Aging and Adult Services

STATEMENT OF MEDICAL STATUS

The purpose of this form is to gather current medical information to use in planning services and care for home and community-based services or nursing facilities. Return the completed form to the patient, support coordinator, ADHC or nursing facility.

I. PATIENT INFORMATION

Name:		Date of Birth:	Gender:
SS#:	Medicaid #:	Medicare #:	
Street Address:		Telephone #:	
City:	State:	Zip Code:	

II. MEDICAL INFORMATION

Diagnoses (include ICD9): Primary:** ___________________________ **Secondary:**________________________________

□ **MRSA** **Other:**

Medications (specify dosage, frequency and route): □ **See Attached** **(May attach patient's Medication Profile, additional medications/procedures or medications/procedures prescribed by other physicians)**

Medication	Dosage	Frequency	Route

Allergies: □ NKDA

Hospitalizations within 2 years (include psychiatric): □ None □ See attached Discharge Summary (if applicable)

Special Care Procedures (check appropriate box): Give type, frequency, size, stage, site, etc., as appropriate

□ Respiratory □ Ventilator □ Daily □ Other	□ Glucose Monitoring □ Insulin Injections □ Daily □ Other
□ Suctioning/Oral Care □ Daily □ PRN	□ Decubitus/Skin Care □ Stage I □ Stage II □ Stage III □ Stage IV
□ Trach Care □ Daily □ PRN	□ Diet/Tube Feeding
□ Urinary Catheter Care	□ IVs
□ Ostomy Care	□ Seizure Precautions
□ Dialysis	□ Restraints
□ Specialized Rehab: Type(s): _____________ Number of Minutes: Last Week: Next Week:	□ Home Health (skill/frequency/duration)
□ DME	□ Other

III. PHYSICAL EXAMINATION INFORMATION

Date of last physical examination:

Date of last **2** office visits: __/___/____; __/___/____

Number of **NEW** orders written in last **14** days:

Height	Weight	Pulse	Resp	Temp	B/P

General: □ WNL	Abdomen: □ WNL
Mouth and ENT: □ WNL	Extremities: □ WNL
Heart and Circulation: □ WNL	Ambulation/Gait: □ WNL
Genitalia: □ WNL	Head and CNS: □ WNL
Skin: □ WNL	Cognitive (include frequency):
Chest: □ WNL	Other:

Physician's Name (type or print): Phone:

Address:

Signature:
(Physician or Physician's PA, NP, RN, LPN) **Date:**

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