**Physician/Physician Assistant/Nurse Practitioner Evaluation**

**Consent for Release of Medical Information**

**Consent Section**

I hereby authorize release of medical information to:

Physician Name:

Physician Address:

Physician Phone: Physician Fax:

I understand that I do not have to sign this consent if it is not clear to me who will provide the information or who will receive the information.

Signature of Individual or Legal Representative Date Signed

Print Individual’s Name Individual’s Date of Birth

**Patient Diagnoses – To be completed by Physician/PA/NP**

**NOTE:** The person named above is either a current resident or a prospective resident of our Assisted Living Residence, which is licensed by the Colorado Department of Public Health and Environment and may be certified by the Department of Health Care Policy and Financing. The license and certification requires that our facility provide non-medical care and supervision to meet the needs of this person. Our Assisted Living Residence requires the following information to assist us in determining whether this person is appropriate for care in our non-medical facility. It is important that all questions be answered completely. Please attach additional pages if needed. ***Our facility does not provide skilled nursing care.***

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Last Exam:  | Height:  | Weight:  | Blood Pressure:  |

**Diagnoses (attach separately if needed):**

**Allergies (medications/food):** [ ]  Yes [ ]  No

*If yes, list allergies and reactions:*

| **Physical Health Status / Mental Condition** | **Yes** | **No** | **Unknown** | **Explain** |
| --- | --- | --- | --- | --- |
| Bladder incontinence | ☐ | ☐ | ☐ | Self-manage? ☐ Yes ☐ No |
| Bowel incontinence | ☐ | ☐ | ☐ | Self-manage? ☐ Yes ☐ No |
| Contagious/infectious disease | ☐ | ☐ | ☐ |   |
| History of skin condition | ☐ | ☐ | ☐ |   |
| Hospitalization for psychiatric condition | ☐ | ☐ | ☐ | If yes, when?  |
| Motor impairment/paralysis | ☐ | ☐ | ☐ |   |
| Seizure disorder | ☐ | ☐ | ☐ | Controlled with meds? ☐ Yes ☐ No |
| Special diet | ☐ | ☐ | ☐ |   |
| Substance abuse issues | ☐ | ☐ | ☐ |   |
| Suicidal/self-abuse | ☐ | ☐ | ☐ | If yes, when?  |

| **Medications –****including OTC (please print)** | **Dosage** | **Route** | **Frequency** | **Reason** |
| --- | --- | --- | --- | --- |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |
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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PRN Medications****(please print)** | **Dosage** | **Route** | **Frequency** | **Reason** |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |

***\*\*A signed/dated medication sheet may be attached if more space is needed.***

***\*\*Please note any medications that require immediate physician notification if the resident refuses a dose.***

Please list (or attach list of) current immunizations:

Recent Hospitalizations/Surgeries:

Length of time individual has been your patient:

Physician/PA/NP Signature Date Signed