# REQUEST FOR MEDICAL INFORMATION

**TO BE COMPLETED BY DOCTOR OR NURSE**

**APPLICANT'S NAME**:_____ **SS #:**_____ **MEDICARE #:** _____

ALLERGIES_____

**PRIMARY DIAGNOSIS**: (ICD9 CODE)_____ **SECONDARY** (ICD9 CODE)_____

OTHER_____

**MEDICATIONS**: (SPECIFY DIAGNOSIS, DOSAGE, FREQUENCY AND ROUTE. PLEASE ATTACH SHEET WITH ADDITIONAL MEDICATIONS IF NECESSARY)

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

**RECENT HOSPITALIZATIONS**: (INCLUDE PSYCHIATRIC)_____

_____

**PHYSICAL EXAMINATION:**

HEIGHT _____ WEIGHT _____ PULSE _____ RESP. _____ TEMPERATURE _____ BLOOD PRESSURE _____

LAB RESULTS: HCT_____ HGB_____ U/A_____ RADIOLOGY _____
GENERAL _____ HEADACHES _____
MOUTH AND EENT _____ CHEST _____
HEART AND CIRCULATION _____ ABDOMEN _____
GENITALIA _____ EXTREMITIES _____
SKIN _____ OTHER _____

**MENTAL STATUS/ BEHAVIOR**: (MARK CORRECT RESPONSE)

| | NEVER | SELDOM | FREQUENT | ALWAYS |
|---|---|---|---|---|
| ORIENTED | _____ | _____ | _____ | _____ |
| FORGETFUL | _____ | _____ | _____ | _____ |
| DEPRESSED | _____ | _____ | _____ | _____ |
| COMBATIVE | _____ | _____ | _____ | _____ |

| | NEVER | SELDOM | FREQUENT | ALWAYS |
|---|---|---|---|---|
| CONFUSED | _____ | _____ | _____ | _____ |
| HOSTILE | _____ | _____ | _____ | _____ |
| WANDER-RISK | _____ | _____ | _____ | _____ |

**PHYSICAL STATUS:** (SELECT APPROPRIATE CHOICE)

_____ VERBAL _____ NON-VERBAL _____ COMATOSE

| | SELF | ASSIST | TOTAL |
|---|---|---|---|
| EATING | _____ | _____ | _____ |
| BATHING | _____ | _____ | _____ |
| PERSONAL | _____ | _____ | _____ |
| ORAL CARE | _____ | _____ | _____ |
| AMBULATION | _____ | _____ | _____ |

_____ IMPAIRED VISION _____ IMPAIRED HEARING
_____ EYEGLASSES _____ HEARING AID
_____ INCONTINENT BOWEL _____ DENTURES:
_____ INCONTINENT BLADDER ____ UPPER
_____ URINARY CATHETER ____ LOWER
_____ OSTOMYCARE ____ PARTIAL

**SPECIAL CARE/ PROCEDURES:** (SELECT CHOICE; WHEN APPROPRIATE GIVE TYPE, FREQUENCY, SIZE, STAGE AND SITE)

GLUCOSE MONITORING _____ TUBE FEEDING _____
RESTRAINTS_____ DIET _____
MRSA/VRE _____ SEIZURES _____
REHAB _____ SUCTIONING_____
DECUBITUS _____ DIALYSIS _____
OTHER

IMMUNIZATIONS: LAST PPD_____ LAST FLU VACCINE _____ LAST PNEUMONIA VACCINE _____

**MD/NURSE PRINTED NAME** _____ **PHONE NUMBER** _____
**ADDRESS** _____ **DATE** _____
**MD/NURSE SIGNATURE** _____