

Date: \_\_\_\_\_

MEDICAL FACT SHEET - PART I - CURRENT INFORMATION

Name: \_\_\_\_\_ Medicaid/Health Insurance Policy ID: \_\_\_\_\_  
SS# \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ Legally competent to make health care decision Yes \_\_\_ No \_\_\_

Next of Kin/Guardian/Health Care Surrogate: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Notified? Yes  No  Notified by: \_\_\_\_\_

Name of Residential Facility: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Name/Telephone # of person who made the decision to refer: \_\_\_\_\_  
Contact for additional information Name/Title/Telephone #: \_\_\_\_\_

Special Problem(s) Needing Attention (describe): \_\_\_\_\_

Current Medications	Purpose	Dose/Schedule	Last Dose

Most recent laboratory results: (attach copies if available)

Date	Test	Results

Assistive devices with individual:  
 Hearing aid     Dentures     Glasses/contact lens     Communication device  
 Wheelchair     Walker     Positioning device     Other \_\_\_\_\_

If going to the hospital Emergency Department, Urgent Care Center, or other service on an emergency basis complete the remainder of this form:

Reason for and condition on departure from home: \_\_\_\_\_

Vital signs before transfer(if available): Temp. \_\_\_\_\_ BP \_\_\_\_\_ HR \_\_\_\_\_ RR \_\_\_\_\_ Pulse \_\_\_\_\_  
oximetry \_\_\_\_\_

Physician Notified: \_\_\_\_\_  
 Primary Care  
 Specialist, specify \_\_\_\_\_

Date of last bowel movement: \_\_\_/\_\_\_/\_\_\_

Date Completed: \_\_\_\_\_  
Date(s) Updated: \_\_\_\_\_

MEDICAL FACT SHEET - PART II - HISTORY

Name: \_\_\_\_\_ Medicaid/Health Insurance Policy ID: \_\_\_\_\_  
SS# \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ Legally competent to make health care decision Yes \_\_\_ No \_\_\_

Next of Kin/Guardian/Health Care Surrogate: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Relationship: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Dentist: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Specialist's name/specialty area/ Telephone: \_\_\_\_\_

Developmental Disability Diagnosis Primary: \_\_\_\_\_  
Secondary: \_\_\_\_\_  
Etiology: \_\_\_\_\_

Allergies: \_\_\_\_\_

Sensitivities: \_\_\_\_\_

Immunizations: Current Yes \_\_\_ No \_\_\_ Date of last Tetanus booster: \_\_\_\_\_  Heptavax  Pneumovax

Significant Medical Conditions /Risk factors (check all that apply):

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Seizure disorder (type _____)        | <input type="checkbox"/> Hx thrombophlebitis                   | <input type="checkbox"/> Hx of drug toxicity               |
| <input type="checkbox"/> On > 2 psychotropic medications      | <input type="checkbox"/> Hx pulmonary embolism                 | <input type="checkbox"/> Prone to decubitus ulcer          |
| <input type="checkbox"/> Psychiatric Dx: _____                | <input type="checkbox"/> Chronic Obstructive Pulmonary Disease | <input type="checkbox"/> Hx liver disease/damage           |
| <input type="checkbox"/> On > 2 antiepileptic medications     | <input type="checkbox"/> Recurrent apnea                       | <input type="checkbox"/> Gastro Esophageal Reflux          |
| <input type="checkbox"/> Intractable seizures                 | <input type="checkbox"/> Sleep apnea                           | <input type="checkbox"/> Hx of GI bleeding                 |
| <input type="checkbox"/> Hyperlipidemia                       | <input type="checkbox"/> Hx aspiration pneumonia               | <input type="checkbox"/> Chronic constipation              |
| <input type="checkbox"/> Hypercholesterolemia                 | <input type="checkbox"/> Recurrent aspiration pneumonia        | <input type="checkbox"/> Swallowing difficulty/dysphagia   |
| <input type="checkbox"/> Hypertension                         | <input type="checkbox"/> Other respiratory conditions _____    | <input type="checkbox"/> Blood dyscrasias                  |
| <input type="checkbox"/> Coronary artery disease              | <input type="checkbox"/> Recurrent infections _____            | <input type="checkbox"/> Cancer                            |
| <input type="checkbox"/> Hx myocardial infarction             | <input type="checkbox"/> Insulin dependent diabetes            | <input type="checkbox"/> Dystonic reaction                 |
| <input type="checkbox"/> Cardiomyopathy                       | <input type="checkbox"/> Non-insulin dependent diabetes        | <input type="checkbox"/> Hepatitis B carrier               |
| <input type="checkbox"/> Heart murmur/mitral valve prolapse   | <input type="checkbox"/> Brittle insulin dependent diabetes    | <input type="checkbox"/> Chronic renal disease             |
| <input type="checkbox"/> Congenital heart disease uncorrected | <input type="checkbox"/> Diabetes insipidus                    | <input type="checkbox"/> Hx of significant self injury     |
| <input type="checkbox"/> Peripheral vascular insufficiency    | <input type="checkbox"/> Prone to dehydration/weight loss      | <input type="checkbox"/> Smoker                            |
|   |  | <input type="checkbox"/> Drinks > 1 serving of alcohol/day |
|   |  | <input type="checkbox"/> Other _____                       |

Physical Limitations: Paralysis: \_\_\_ Scoliosis: \_\_\_ Contractures: \_\_\_

Others: \_\_\_\_\_

Comments:

**History of Hospitalizations during past 2 years and any surgery requiring hospitalization during lifetime:**

Date	Hospital	Length of Stay	Reason

**Emergency Room Visits for Past Year:**

Date	Hospital/Reason	Outcome

**Special Consultations within last 5 Years:**

Date	Specialty	Physician

**Special diagnostic tests done within the past 5 years:**

Date	Test	Results

Date of most recent chest x-ray and result: \_\_\_\_\_

Date of last physician visit & findings: \_\_\_\_\_

Date of last physical examination and significant findings: \_\_\_\_\_

Summary of clinical course within past 12 months (Attach if needed)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>Diet:</b> <input type="checkbox"/> Regular <input type="checkbox"/> Low fat <input type="checkbox"/> Low sodium ___gms <input type="checkbox"/> ADA ___calories <input type="checkbox"/> Renal diet <input type="checkbox"/> Other: _____ <input type="checkbox"/> Formula	<b>Manner of Eating:</b> <input type="checkbox"/> Feeds self <input type="checkbox"/> Needs prompting and observation <input type="checkbox"/> Needs some physical assistance <input type="checkbox"/> Total assistance <input type="checkbox"/> Gastrostomy/jejunostomy <input type="checkbox"/> Needs special positioning	<b>Diet Consistency:</b> <input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed <input type="checkbox"/> Thickened liquids <input type="checkbox"/> Liquid
<input type="checkbox"/> Edentulous <input type="checkbox"/> Wears dentures		

**Ambulation:**  Walks  Unsteady gait  Uses walker/cane  Uses wheelchair  
 Requires assistance/observation, with any above ambulation

**Assistive/Prosthetic/Positioning device:** Yes \_\_\_ No \_\_\_

Type: \_\_\_\_\_ Frequency of use: \_\_\_\_\_

**Toileting:**  Independent  Requires verbal prompt  Requires physical assistance  
 Uses diaper Urinary Frequency: \_\_\_\_\_

Bowel frequency \_\_\_\_\_ Special instruction re: Bowel management \_\_\_\_\_

**Communication:**  Verbal  Understands but can't speak  Gestures  
 Uses communication device Type of device: \_\_\_\_\_

**Vision:** \_\_\_\_\_  Wears glasses/contact lens

**Hearing:** \_\_\_\_\_  Wears hearing aid  Lip reads

**Activities enjoyed:**

**Behaviors that may interfere with treatment or care and interventions successful in the past:**

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