



Physician Summary Form

This form verifies and validates the medical information provided by your patient or the patient's legal guardian. This form must be returned as soon as possible. Without this information, your patient's ability to initiate or continue to receive timely MassHealth services may be impacted.

Patient

Last name	First name	Date of birth	Gender <input type="checkbox"/> F <input type="checkbox"/> M
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Diagnosis

Diagnosis(es)	<input type="checkbox"/> Mental illness (indicate diagnosis): <hr/> <input type="checkbox"/> Intellectual disability <input type="checkbox"/> Developmental disability
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Treatments

List type and frequency.

Medications (use back of form for additional medications)

List drug, dose, route, and frequency.

Skilled Therapy

Direct therapy by OT, PT, ST

Recent vital signs Date : T: _____ P: _____ R: _____ BP: _____	Allergies <input type="checkbox"/> No known allergies <input type="checkbox"/> No known drug allergies <input type="checkbox"/> Allergies, list: _____ _____	Height _____ Weight _____	Continance Bowel <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Colostomy Bladder <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheter	Mental Status <input type="checkbox"/> Alert & oriented <input type="checkbox"/> Alert & disoriented <input type="checkbox"/> Other: _____
Additional comments/Special needs _____ _____ _____			Recent Lab work _____ Diet: _____	Date of last physical exam _____ Date of last office visit _____

I recommend this patient for the following service(s)

<input type="checkbox"/> Adult day health (ADH)	<input type="checkbox"/> Group adult foster care (GAFC)	<input type="checkbox"/> Adult foster care (AFC)	<input type="checkbox"/> Program for All-inclusive Care for the Elderly (PACE)	<input type="checkbox"/> Nursing facility (NF)
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I certify that the information on this form, and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Provider's signature _____
 (Signature and date stamps, or the signature of anyone other than the provider are not acceptable.)

MD/NP/PA (Circle one.)

Print name: _____

Date completed: _____

Print address: _____