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?

Physical Health Status / Mental Condition	Yes	No	Unknown	Explain
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

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

INSTRUCTIONS

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This document is faxed to the individual's physician, physician assistant (PA) or nurse practitioner (NP) for completion. The ALR may, after faxing over proof of consent, also call the doctor's office to obtain information. Alternatively, the individual may take this form to an appointment at the doctor's office and request that the document be completed at that time.

If the individual sees more than one physician, this form may be completed by each.

It is likely that the physician/PA/NP will not answer all of the questions. It is the facility's responsibility to gather the needed information about the individual's health status, and through the initial assessment process, obtain all the information needed in order to make any decision about admitting the individual to your Assisted Living Residence.

Consent Section:

1. Individual enters the name of the medical practitioner who will complete the form.
2. ALR staff or individual enters address, phone, and fax number.
3. After reading the consent statement, the individual or legal representative signs and dates the consent section.
4. The individual prints their name and enters their birth date.
5. Enter the name of the individual in the document's header, starting on page 2.

The document is now ready to be mailed or faxed to the person noted on the top of the form.