

## 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):
	<input type="checkbox"/> Intellectual disability <input type="checkbox"/> Developmental disability

### \* Treatments

List type and frequency.

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### \* Medications (use back of form for additional medications)

List drug, dose, route, and frequency.

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### \* Skilled Therapy

Direct therapy by OT, PT, ST

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<b>Recent vital signs</b> Date : T: _____ P: _____ R: _____ BP: _____	<b>Allergies</b> <input type="checkbox"/> No known allergies <input type="checkbox"/> No known drug allergies <input type="checkbox"/> Allergies, list: _____	<b>Height</b> _____	<b>Contingence</b> 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	<b>Mental Status</b> <input type="checkbox"/> Alert & oriented <input type="checkbox"/> Alert & disoriented <input type="checkbox"/> Other: _____
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### Additional comments/Special needs

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Recent Lab work _____	* Date of last physical exam *
Diet: _____	* 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 checked="" 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 \_\_\_\_\_ MD/NP/PA (Circle one.)  
(Signature and date stamps, or the signature of anyone other than the provider are not acceptable.)

\* Print name: \_\_\_\_\_ \* Date completed: \_\_\_\_\_

\* Print address: \_\_\_\_\_