Physician's Evaluation Form

1. NAME (Last, First, Middle Initial)	2. BIRTHDATE	3. SEX

4. HEALTH STATUS (to be completed by physician)

A. LIST CURRENT SIGNIFICANT DIAGNOSIS(ES):

PRIMARY: ❒ Intellectual Disability ❒ Cerebral Palsy ❒ Epilepsy
❒ Pervasive Developmental Disorder such as Autism

❒ Other: _____

B. MEDICATIONS

List all Significant Medications, Dosage and Frequency. If administered by IV or IM, check column to the right. (As an option, attach treatment sheet with same information.)

	IV/IM
	[ ]
	[ ]
	[ ]
	[ ]
	[ ]
	[ ]

C. VISION, HEARING, SPEECH (check appropriate box)

Evaluation Category	Normal or Minimal Problem	Impairment	Complete Absence
Vision	❒	❒	❒
Hearing	❒	❒	❒
Speech	❒	❒	❒

D. MEDICAL SUPPORTS NEEDED (check appropriate box)

Medical Support	No Support Needed	Some Support Needed	Extensive Support Needed
Respiratory Care			
Ventilator	❒	❒	❒
Oxygen therapy	❒	❒	❒
Postural drainage	❒	❒	❒
Chest PT	❒	❒	❒
Suctioning ❒ w/ tracheostomy ❒ w/o tracheostomy	❒	❒	❒
Skin Care			
Turning or positioning	❒	❒	❒
Dressing of open wound(s)	❒	❒	❒
Other Medical Support			
Protection from infectious diseases due to immune system impairment	❒	❒	❒
Seizure management	❒	❒	❒
Dialysis	❒	❒	❒
Ostomy care (identify the kind of ostomy) _____	❒	❒	❒
Enuresis or encopresis (urinary/bowel hygiene)	❒	❒	❒
Tube feeding (e.g., nasogastric, gastrostomy tube)	❒	❒	❒
Lifting and/or transfers	❒	❒	❒
Therapy services ❒ PT ❒ OT ❒ Speech	❒	❒	❒
Urinary Catheterization	❒	❒	❒

Diet Order (if necessary):

Self-preservation: Patient is physically and mentally capable of following instructions and taking appropriate action for self-preservation in the event of fire or other emergency? Yes ❒ No ❒

E. COMMUNICATION & BEHAVIOR

COMMUNICATION:

[ ] Adequately communicates needs/wants, including with the use of sign language, interpreter, gestures and devices

[ ] Has difficulty communicating needs/wants

BEHAVIOR:

[ ] No mood/behavioral issues

[ ] Persistent anger with self or others

[ ] Self deprecation

[ ] Unable to communicate needs/wants MEMORY [ ] Normal or minimal impairment of memory [ ] Problem with [ ] long term or [ ] short term memory or [ ] both	[ ] Unrealistic fears [ ] Insomnia [ ] Pained, worried facial expressions [ ] Crying, tearfulness [ ] Repetitive physical movements [ ] At risk for self-inflicted harm [ ] Other _____

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Additional information/comments relating to individual's health status. Note any significant health issues such as diabetes, hypertension, allergies, etc.

PHYSICIAN'S SIGNATURE: _____ **DATE:** ____/____/____

Physician's Name: _____ PHONE #: _____

FAX #: _____