# UPCAP LONG TERM CARE PROGRAMS
# RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

**PHYSICIAN**: ______________________________________________

**ADDRESS**: ______________________________________________

______________________________________________

**CLIENT**: ______________________________________________ **D.O.B**:__________/__________/__________

______________________________________________

______________________________________________

The above-named person has been assessed and deemed eligible for enrollment into UPCAP's Care Management Program. The medical information being requested is necessary to validate medical eligibility and is also useful in determining service eligibility. We request this information based on your knowledge of the above named individual and to facilitate our development of a service care plan.

**DIAGNOSIS:** Primary: ______________________________________________

Secondary:______________________________________________

Chronic Illness: Yes_____ No_____

**PROGNOSIS**: ______________________________________________

**DATE INDIVIDUAL WAS LAST SEEN**: ____________________________

**DOES INDIVIDUAL NEED TO BE ACCOMPANIED TO MEDICAL APPOINTMENTS?** YES_____ NO _____

**AMBULATORY STATUS**: Independently With Assist Non-Ambulatory

| NAME AND STRENGTH | FREQ. | PRESCRIBING M.D. | NAME AND STRENGTH | FREQ. | PRESCRIBING M.D. |
|---|---|---|---|---|---|
| | | | | | |
| SEE ATTACHED MEDICATION LIST | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**ALLERGIES w/ DOCUMENTED REACTIONS:**

**RECENT SURGERY DATE**: ________________________ If applicable, please describe: ________________________

______________________________________________

**DIET:** ______________________________________________

**CONTINUED ON REVERSE SIDE**

**UPCAP'S SUPPORTS COORDINATORS ASSESSED THE NEEDS IN THE BELOW CATEGORIES:**

| **PERSONAL CARE ACTIVITIES:** | | **SERVICES NEEDED:** | |
|---|---|---|---|
| ___Eating | ___Dressing | ___Specialized Feeding | ___Range of Motion |
| ___Meal Preparation | ___Toileting | ___Suctioning | ___Colostomy Care |
| ___Transferring | ___ Shopping/Errands | ___Catheters or leg Bags | ___ Bedsore Prevention |
| ___Bathing | ___Mobility | | |
| ___Laundry | ___Grooming | ___Other___________________________________ | |
| ___Taking Meds | ___Housework | | |

**DO YOU AGREE AND CERTIFY NEED FOR ASSISTANCE? _____ YES _____ NO**

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**ADDITIONAL COMMENTS / HISTORICAL BACKGROUND WHICH MAY BE BENEFICIAL IN SERVING OUR CLIENT:

COMMENTS:

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* By my signature, I attest that the information above is accurate and up-to-date. I agree that this client would benefit from in home services and participation in UPCAP's Care Management/Waiver Program.

**Physician Signature**: ___________________________________________________**Date:**________________________________

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## CLIENT AUTHORIZATION OR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

I, _________________ _____________________________________, am voluntarily participating in UPCAP's LTC Programs. I have been informed of this request for medical information and hereby authorize release of all medical records and relevant information which may be requested as a result of my participation in this program. This authorization will expire on ___________________.

________________________________________________________ ________________________________

**Client's (Authorized Representative) Signature** **Date**

________________________________________________________ ________________________________

**Witness or Supports Coordinator Signature**

**Date**

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**PLEASE RETURN THIS FORM (OR A COPY) TO:**

**UPCAP – Long Term Care Programs**

**Thank you for your assistance. If you have any questions, please call us at**