MassHealth

Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

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 ☐ F ☐ M

Diagnosis

Diagnosis(es)	☐ Mental illness (indicate diagnosis):
	☐ Intellectual disability ☐ Developmental disability

Treatments

List type and frequency.

Skilled Therapy

Direct therapy by OT, PT, ST

Medications (use back of form for additional medications)

List drug, dose, route, and frequency.

Recent vital signs		Allergies	Height	Continence		Mental Status
Date :	T:	☐ No known allergies ☐ No known drug allergies		Bowel	Bladder	☐ Alert & oriented
	P:	☐ Allergies, list:	Weight	☐ Continent	☐ Continent	☐ Alert & disoriented
	R:			☐ Incontinent	☐ Incontinent	☐ Other:
	BP:			☐ Colostomy	☐ Catheter	

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)

☐ Adult day health (ADH) ☐ Group adult foster care (GAFC) ☐ Adult foster care (AFC) ☐ Program for All-inclusive Care for the Elderly (PACE) ☐ Nursing facility (NF)

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 then the provider are not acceptable.)

Print name: _____ Date completed: _____

Print address: _____