

Fact & Medical Sheet

Date of application for services:
Referred by:
Reason for referral:

Name:	DOB:
SSN#:	Sex: Marital Status:
Home Address:	Home phone: Work phone:
Mother's Name:	Address:
Home phone:	Work phone:
Father's Name:	Address:
Home phone:	Work phone:
Additional contact:	Phone:
Additional contact:	Phone:
Additional contact: N/A	Phone:
Agency contact person:	Phone:
Daytime/work contact:	Phone:
Case Manager:	Phone:
DDD Social Worker:	Phone:
Method of communication:	Registered voter: Y / N
Language spoken/understood:	
Response to emergency/ Self preservation:	
Guardianship/Financial: Self/Other	Guardianship/Medical: Self/Other
Special considerations:	
Primary insurance coverage:	Preferred medical center/hospital:
Medicare:	Advanced directive on file: Y / N
Medicaid:	Date of last tetanus booster:
Current source of income and amount:	
Allergies:	Date of last physical:
Height:	Weight:
Eye color:	Hair color:
Religion:	Place of worship:
Medical Diagnosis:	Secondary Diagnosis:

Specific Medical Concerns:	
Current Medications: Always confirm current medications including name, dosages, and times given before using this information to treat.	
Primary care physician's name, address and phone:	
Additional physicians name and specialty:	Phone:
1.	
2.	
3.	
4.	
5.	
6.	
Prepared by:	Updated on:
Reviewed by Nursing Department:	Reviewed by UCM Supervisor:

Considerations not otherwise addressed:

