

MEDICAL INFORMATION RELEASE

THIS REPORT MUST BE DATED WITHIN 14 DAYS PRIOR TO RECEIPT OF THE APPLICATION BY THE NORTHEAST LA WAR VETERANS' HOME
A CHEST X-RAY, PPD AND A VDRL MUST BE ACCOMPLISHED WITHIN 48 HOURS OF ADMISSION TO THE HOME

NAME OF APPLICANT _____

Reason for Referral: _____

Past Medical/Surgical/Psychiatric Diagnoses and Treatment(s) Provided: (List Dates)

History of Substance Abuse (If within past 12 months, list completed treatment program)

Diagnostic Procedures and Findings (List all procedures employed in establishing diagnoses and your findings from all X-rays, laboratory tests, CT Scans, MRI's, etc.)

Immunization Date: _____

If history of positive PPD, was treatment received? If so, when? _____

Results of PPD _____ (Attach a copy of test results)

Pneumovac-Date Administered _____

Influenza-Date Administered _____

VDRL (List the date given) _____ (Attach a copy of test results)

OXYGEN: Yes _____ No _____ Continuous _____ PRN _____

Signature of Physician

Date