Rhode Island Department of Elderly Affairs (DEA)

Medical Assessment for DEA Home & Community Based Care

Instruction: Attached a completed and signed copy of RIDEA Form 20-01 A-M. Rev. 06/2003, Authorization to Obtain or Release Confidential Client Medical Information and/or RIDEA Form 20-01 A-P Rev. 06/2—3, Authorization to Obtain or Release Confidential Client Psychotherapy Information.

Dear Doctor: Date: _____

Please complete this request for assessment information regarding your patient, _____, who has given authorization to release this information by signing the attached form. Thank you very much.

1. Date of last office visit: _____
2. Diagnosis (including relative severity of condition, medications and treatments):

_____
_____
_____
_____

3. Prognosis of disability:

Permanent	_____Yes	_____No
Temporary	_____Yes	_____No

4. Does the Patient require assistance with the following?

Cleaning	_____Yes	_____No
Laundry	_____Yes	_____No
Meal Preparation	_____Yes	_____No
Ambulation	_____Yes	_____No
Toileting	_____Yes	_____No
Bathing/Dressing	_____Yes	_____No

5. Can Patient go out unassisted? _____Yes _____No

Signature: _____ Date:_____

Please return this form to:

Signature of Case Manager	Number	Street
Agency	City/Town	Zip Code