Carbon-Monroe-Pike MH/MR Program

Annual Certification for Waiver Services Physician Form

Consumer Name: _____ Birthdate: _____ Date of Examination: _____

Medical Summary (history, Diagnosis, allergies):_____

_____

Height: _____ Weight: _____ Blood Pressure: _____

System Area:	Normal Findings: Yes	No	Comments:	System Area:	Normal Findings: Yes	No	Comments:
Eyes	☐	☐	_____	Breasts	☐	☐	_____
Ears	☐	☐	_____	Lungs	☐	☐	_____
Nose	☐	☐	_____	Cardiovascular	☐	☐	_____
Throat/ Mouth	☐	☐	_____	Extremities	☐	☐	_____
Head/ Neck	☐	☐	_____	Abdomen	☐	☐	_____
Gastrointestinal	☐	☐	_____	Muscular-skeletal	☐	☐	_____
Integumentary	☐	☐	_____	Urinary/Renal	☐	☐	_____
Reproduction	☐	☐	_____	Lymphatic	☐	☐	_____
Endocrine	☐	☐	_____	Nervous System	☐	☐	_____

ICF/ MR Level of Care required: ☐ Yes ☐ No Services to be provided at home or in an intermediate care facility

Physical Limitations: _____

_____

Vaccinations: _____ Tetanus _____Diphtheria _____ Mantoux/Chest X-Ray Results: _____

Is the Individual Free of Communicable Diseases? ☐ Yes ☐ No Comments: _____

Physician Recommendations: _____

_____

Medications: _____

_____

Dietary and Therapy Needs: _____

_____

Name of Physician: _____ Phone: _____

Please Print

Signature: _____ Date: _____

Please have your physician complete this form and return to:

Rebecca Berghoefer, Waiver Coordinator
Carbon-Monroe-Pike MH/MR Program
730 A Philips Street
Stroudsburg, PA 18360-1799
Phone: (570)420 1900 Fax: (570)421 6849