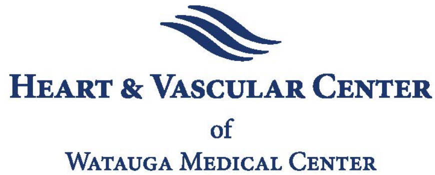

Patient Name________________________________
Date of Birth________________________________
MRUN Number________________________________
Please Fill in or Affix a Patient Label

Established Patient

Room ____________

Date: ____________

Patient Name: ______________________________ Weight: __________ Height: ______ BMI: ____________

Primary Care MD: ______________________________ Age: __________

Blood Pressure: Supine: _______ Sitting: ___________ Standing: _______ Pulse: _____ O2: ____________

Food/Drug Allergies ☐ No ☐ Yes ____

Hypertension ☐ No ☐ Yes

Diabetes Mellitus ☐ No ☐ Yes ☐ NIDDM ☐ IDDM

Elevated Cholesterol ☐ No ☐ Yes Date of ______ Last Cholesterol _______ Trig _____ HDL _____ LDL _____

History of tobacco use ☐ No ☐ Yes Active ☐ Yes ☐ No: Pkg/year __________ Quit Date: ______________

Date of last chest X-Ray: ______________ Where? ______________________________

Date last seen by TCC MD: ☐ Office ______________________ ☐ Hospital ______________________

Complaints: Chest Pain ☐ Yes ☐ No Palpitations ☐ Yes ☐ No SOB ☐ Yes ☐ No

Need any medication refills? ☐ Yes ☐ No If Yes, please list them:

In the past 4 weeks have you had any problems with balance or falling? ☐ YES ☐ NO ☐ Non-ambulatory

In the last year have you fallen 2 or more times or had a fall with injury? ☐ YES ☐ NO ☐ Non-ambulatory

Reason for visit? ____

____

____

____

Plan ____

____

____

____

____

Follow up treatment plan:

- ☐ Patient recommended to follow-up with primary care provider.
- ☐ Recommend referring patient to PT/OT for balance/gait/strength
- ☐ Advise patient to remove trip hazards
- ☐ Reviewed medications that could increase fall risk
- ☐ Recommended Vitamin D supplements daily
- ☐ Patient declines the referral recommended above

Provider Signature ▶	Date: Time:
Provider Name *(Please Print)* ▶	

Form Number: 11648

Effective Date: Not Set
Revised Date: 08/03/2020