MassHealth Physician Summary Form

Patient

Last name	First name	Date of birth	Gender F M	SSN

Diagnosis

Diagnosis(es)	☐ Mental retardation
Psychiatric diagnosis	☐ Developmental disability

Treatments
List type and frequency.

Medications taken
List drug, dose, route, and frequency.

Ordered therapies
by a licensed professional (OT, PT, ST, etc.)

Recent vital signs		Allergies	Height	Continence		Mental Status
Date:	T:	☐ No known allergies ☐ No known drug allergies		Bowel	Bladder	☐ Alert & oriented
	P:	☐ Allergies, list:	Weight	☐ Continent	☐ Continent	☐ Alert & disoriented
	R:			☐ Incontinent	☐ Incontinent	☐ Other:
	BP:			☐ Colostomy	☐ Catheter	

Additional comments/Special needs

Lab work

Date of last P.E.

Date of last office visit

I recommend this patient for the following service(s)

☐ Adult day health (ADH)	☐ Group adult foster care (GAFC)	☐ Adult foster care (AFC)	☐ Program for All-inclusive Care for the Elderly (PACE)	☐ Nursing facility (NF)

Signature _____ MD/NP/PA (circle one)

Print name _____ Date completed _____

PSF-1 (07/02)