



Nurses House, Inc.
The Veronica M. Driscoll Center for Nursing
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HEALTH STATUS REPORT

CLIENT RELEASE: I hereby authorize release of the requested information to Nurses House and I authorize my provider to speak with a representative of Nurses House.

CLIENT SIGNATURE _____ DATE _____

NAME _____

ADDRESS _____

INITIAL SERVICE DATE _____ LAST VISIT DATE _____

ICD-10-CM CODE(S) _____

DIAGNOSIS/ES _____

CURRENT HEALTH STATUS & TREATMENT REGIME _____

PROGNOSIS: Fair__ Poor__ Guarded__ Terminal__ Good__ Excellent__ Unknown__

IS CLIENT ABLE TO WORK AT THIS TIME? YES__ FT__ PT__ NO__

LIMITATIONS _____

IF NOT, PROJECTED RETURN DATE _____

PRINT OR TYPE PROVIDER NAME _____

LICENSE # _____ TELEPHONE # _____

ADDRESS _____

PROVIDER SIGNATURE _____ DATE _____