CLINICIAN'S INFORMATION

For use of this form, see AR 608-75; the proponent agency is OACSIM.

PERMISSION FOR RELEASE OF MEDICAL INFORMATION

I agree to the release of medical information to the ACS Respite Care Program.

(Date) *(Signature of Patient or Responsible Parent)*

FOR CLINICIAN

Application is being made to the ACS Respite Care Program to receive respite care services. Respite care is temporary relief care given by caregivers, trained and certified by ACS to help children and adults with disabilities, many of whom are developmentally disabled in order to provide a respite period for family members responsible for their regular care. Respite care can vary in length from a few hours to a week or more. The program provides two levels of respite care: supervision only and personal care.

We need to know, therefore, the level of care the applicant requires and any relevant information about medical conditions and special care instructions. Would you please provide the answers to the questions on this form and give explanations when indicated. This information is for confidential use.

NAME *(Patient)*	BIRTHDATE *(YYYYMMDD)*
ADDRESS	

IF APPLICANT REQUIRES ANY PERSONAL CARE, EXPLAIN HOW CARE IS NEEDED.

BATHING
SKIN AND HAIR CARE
SHAVING
FEEDING
TRANSFERRING
LIFTING
ASSISTIVE DEVICES
TOILETING
ADMINISTRATION OF MEDICATION
EXERCISING
MONITORING OF BODY FUNCTIONS
OTHER

IF APPLICANT REQUIRES SUPERVISION WHEN PERFORMING CERTAIN FUNCTIONS FOR HIMSELF/HERSELF, EXPLAIN SUPERVISION NEEDED.
BATHING AND BODY CARE
TOILETING
MOBILITY
USE OF MEDICATIONS
USE OF ASSISTIVE DEVICES
MENTAL FUNCTIONS *(Including capacity for sound judgment)*
NUTRITIONAL NEEDS
OTHER
IF THERE IS ANY RELEVANT INFORMATION NOT DESCRIBED ABOVE THAT THE CAREGIVER SHOULD BE AWARE OF, PLEASE EXPLAIN.
MEDICAL CONDITIONS
MEDICATIONS
SPECIAL DIETS
SPECIAL CARE
OTHER
PHYSICIAN *(Name, address and telephone number) (Type or print)*

DATE *(YYYYMMDD)*	SIGNATURE