



MEDICAL INFORMATION FORM

Patient Name																						
SS#	-	-	Date of Birth	Date of Stroke																		
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:33%;">Medications</th> <th style="width:33%;">Dosage</th> <th style="width:33%;">Frequency</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>					Medications	Dosage	Frequency															
Medications	Dosage	Frequency																				
Allergies																						
Neurological conditions (please circle):																						
Alzheimer's disease	Dementia	Seizures																				
Cognitive deficits (specify)	Head injury	Syncope																				
CVA (specify)	Primary progressive aphasia																					
Other conditions (please circle):																						
Chemical dependency	Heart disease	Mental illness																				
Chronic headaches	Hemi paresis	Visual field deficits																				
Diabetes	Hypertension	Other:																				
Dietary Restrictions:																						
Date of Last Completed Physical/Neurological Exam:																						
How often do you see this patient?																						
Do you feel your patient would be physically capable of participating in an intensive speech-language program?			<input type="checkbox"/> Yes	<input type="checkbox"/> No																		
Would your patient require any medical monitoring if involved in our program?			<input type="checkbox"/> Yes	<input type="checkbox"/> No																		
If yes, please describe: _____																						

MD Orders: "I recommend that this patient participate in the Intensive Aphasia Program at North Memorial Medical Center, with 3.5 hours of therapy per day, 5 days per week, for 3 weeks, from _____ to _____." Initials:																						
Physician's Signature																						
Physician's Name (please print)																						
Street Address		City	State	Zip																		
Phone ()		Date																				
Physician's UPIN #																						