HEALTH STATUS REPORT

CLIENT RELEASE: I hereby authorize release of the requested information to Carin for Nurses and I authorize my provider to speak with a representative of Carin for Nurses.	
CLIENT SIGNATURE	**DATE**

PATIENT INFORMATION:			
NAME			
ADDRESS			
INITIAL SERVICE DATE		**LAST VISIT DATE**	
ICD-9-CM/ICD-10-CM CODE			

DIAGNOSIS/ES:

CURRENT HEALTH STATUS & TREATMENT REGIME:

PROGNOSIS:						
FAIR	**POOR**	**GUARDED**	**TERMINAL**	**GOOD**	**EXCELLENT**	**UNKNOWN**

IS PATIENT ABLE TO WORK AT THIS TIME?		
YES – FULL TIME	**YES – PART TIME**	**NO - UNABLE TO WORK**
WORK LIMITATIONS:		**PROJECTED RETURN DATE:**

TREATMENT PROVIDER INFORMATION:			
NAME			
LICENSE #		**TELEPHONE #**	
ADDRESS			

TREATMENT PROVIDER SIGNATURE	**DATE**