The Iris Network Rehabilitation Center
Request for Medical Information

Patient Name:

Patient DOB:

I GIVE MY PERMISSION TO RELEASE THE FOLLOWING INFORMATION TO THE IRIS NETWORK REHABILITATION CENTER.

Patient Signature:

Checking this box indicates an electronic signature: ☐

Date:

Primary Diagnosis:

Secondary Diagnosis:

General Health:

Date of Last Exam:

Does patient have a seizure disorder? ☐Yes ☐No

If yes, date of last seizure:

Mental health diagnosis, if any:

PLEASE ATTACH A LIST OF PRESCRIBED MEDICATIONS.

Does patient have any difficulties with memory and/or cognition? ☐Yes ☐No

Does patient have any restrictions on fine or gross motor activity? ☐Yes ☐No

Is patient able to ambulatory? ☐Yes ☐No

Is patient able to climb stairs? ☐Yes ☐No

Other restrictions/concerns/recommendations:

It is my medical opinion that

☐is / ☐is not in good general physical and mental health and

☐is able / ☐is not able to withstand the rigors of a 3-5 month, 40 hour per week residential vocational training program at The Iris Network Rehabilitation Center.

Signature of physician:

Date of signature: