APPENDIX E

PHYSICIAN REVIEW FORM

REQUEST FOR PHYSICIAN REVIEW OF ASSESSMENT RESULTS AND ACTION PLAN FOR *INDEPENDENT LIVING AND MOBILITY STUDY (ILAMS)*

To assure timely response to your patient's needs, please respond by fax. It is important that you let us know that you received the Assessment Results and Action Plan, as well as to let us know if you have any concerns with the recommendations in the Action Plan. Thank you.

1st Fax Date: _____ # of Pages _____
2nd Fax Date: _____ # of Pages _____

To: _____ From: _____
Phone # _____ Fax # _____ Phone # _____ Fax # _____
Office Contact: _____
Your patient has authorized us to talk with you. Attached is the completed and signed HIPAA authorization to do so. This fax pertains to the **ILAMS Assessment Results and Action Plan** for:

Participant Name: Date of Birth:

Explanation of the attached ILAMS Assessment Results and Action Plan:

Your patient (named above) is a participant in the Independent Living and Mobility Study (ILAMS), a national Fall Prevention Demonstration Project, sponsored by the Department of Health and Human Services. Please see the attached Summary of Assessment Results and Action Plan. The patient was assessed at telephonically on {DATE} and at home on {DATE}.

PHYSICIAN RESPONSE to the findings of the ILAMS Assessment and Action Plan:

Please check all that apply, Then sign and date below

☐ I RECEIVED THE ASSESSMENT RESULTS AND ACTION PLAN.

☐ I HAVE THE FOLLOWING CONCERNS WITH THE ACTION PLAN:

_____

_____

☐ I WOULD LIKE A COPY OF THE COMPLETE ILAMS ASSESSMENT SENT TO ME FOR INCLUSION IN THIS PATIENT'S MEDICAL RECORD.

Physician Signature: _____ Date: _____

PLEASE FAX THIS COMPLETED FORM TO XXX-XXX-XXXX. Thank you.