MEDICAL APPLICATION

The FASNY Firefighter's Home

P: (518) 828-7695 / (800) 479-7695
F: (518) 828-1092
W: www.firemenshome.com
E: firemenshome@fasny.com

Mail to:
Attention: Admissions Department
125 Harry Howard Avenue
Hudson, NY 12534

MEDICAL CERTIFICATE COVER SHEET

Please provide any medical data pertinent for this application to the Firefighter's Home. Below are some directions to help in the completion of all necessary forms.

NOTE: If currently hospitalized, some of the below items are not required. Please inquire with our Admissions Specialist.

Include the following with the Medical Certificate:

1) History and Physical – to be completed by your medical provider
2) Medical Records – from all current treating providers
    - ➔ Cardiac
    - ➔ Urology
    - ➔ Neurology
    - ➔ Therapies (OT, PT, Speech, etc.)
    - ➔ Psychiatric
3) Hospital Discharge Summaries (if coming from hospital)
4) PRI and Screen – only good for 90 days post completion
5) List of Current Medications

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AUTHORIZEATION FOR RELEASE OF INFORMATION

Name:_____

Date of Birth:_____ SSN:_____

The undersigned hereby authorizes and requests

_____

PHYSICIAN OR PRACTICE NAME

to provide the Firefighter's Home, 125 Harry Howard Avenue, Hudson, NY 12534, copies of the Medical Records of the above named patient for the purpose of admission to the Firefighter's Home.

Any exception to the information to be released is as follows: _____

_____

_____

_____

_____

The request for information is limited to admission or hospital services commencing:

_____

DATE

It is understood that this authorization may be revoked by me at any time (in writing) and will automatically expire ninety (90) days after the date of signature.

_____

PHYSICIAN OR PRACTICE NAME

is released from all legal responsibility which may arise from the release of requested information.

Date:_____ Signature of Patient:_____

Date:_____ Signature of Witness:_____

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MEDICAL CERTIFICATE

Date: _____

Applicant's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

NYS County: _____ Marital Status: _____ Tobacco Use: _____

Place of Birth: _____ Date of Birth: _____ Alcohol Use: _____

Medicare Number: _____ Religion: _____

DATE OF:

Last Chest X-Ray _____ Pneumovac _____ Flu Shot _____

Mantoux _____ Results _____

COVID Vaccinations _____

Mantoux Test Is Required for Admission

Current Complaint/Reason for Admission to the Firefighter's Home: _____

_____

Pertinent Past Medical History: _____

_____

Medications: _____

_____

Allergies: _____

Family Medical History: _____

_____

Social History (Smoking, Alcohol use, etc.): _____

_____

ROS General:

HEENT: _____

CV: _____

Pulm: _____

GI: _____

Note: Completed form good for 90 days post date.

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GU:_____

MIS:_____

Neuro:_____

Endocrine: _____

Psychiatric:_____

PHYSICAL EXAMINATION:

Temp:_____ B.P._____P._____ R._____

Height_____ Weight:_____

GENERAL:

HEENT:_____

Neck: _____

Heart:_____

Lungs:_____

Breasts:_____

Abdomen:_____

Genital:_____

Rectal:_____

Extremities:_____

Neurological:_____

Skin:_____

MD Signature:_____Date:_____

Please print: Name: _____

Address:_____

City:_____ State:_____ Zip._____

Phone Number:_____

Reviewed by Firefighter's Home Physician:_____

Dated on:_____

Note: Attach hospital discharge summaries and relevant medical information.

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