Medical Assessment Form PA 635

General Information

- **Patient Name: _____**
- **Patient ID: _____**
- **Assessment Date: _____**
- **Assessor's Name: _____**
- **Assessor's Contact: _____**

Medical Background

- **Current Diagnosis: _____**
- **Relevant History: _____**
- **Current Treatment Plan: _____**

Functional Assessment

- **Mobility: [ ] Fully Mobile [ ] Partially Mobile [ ] Immobile**
- **Cognitive Function: [ ] Intact [ ] Impaired**
- **Communication Ability: [ ] Normal [ ] Limited [ ] Non-Verbal**

Specialist Referrals

- **Referral to Specialist: [ ] Yes [ ] No**
  - **If Yes, Specify: _____**

Assessment Summary

- **Key Findings:**

  _____
- **Additional Notes:**

  _____

Signature and Certification

I hereby certify that this assessment is accurate and based on my professional evaluation.

- **Assessor's Signature: _____**
- **Date: _____**