Michael Shahnasarian, Ph.D.
Certified Rehabilitation Counselor #3701
Certified Vocational Evaluator #58360
Certified Life Care Planner #258
Licensed Psychologist PY5644
Fellow, National Career Development Association
Fellow, International Academy of Life Care Planners

AUTHORIZATION FOR RELEASE OF MEDICAL AND OTHER PATIENT INFORMATION

Patient Name________________________ **Date of Birth**_________________

By signature of this letter, I authorize Dr. Michael Shahnasarian to consult with treating professionals who have provided medical care to me. I understand that the consultation may involve inquiry into my physical limitations and capabilities, mental health issues, and projected medical care needs.

______________________________ ________________

Signature of Patient or Guardian **Date**

____

Print Name of Patient or Guardian

____

Relationship to Patient

11019 North Dale Mabry Highway
Tampa, FL 33618
813-265-9262 813-265-4226 FAX

Date

Doctor
Address

RE: _________________

Dear:

Attached is a Life Care Plan developed for ________________________.

Thank you for your assistance in identifying the future needs anticipated for _________________. Please let us know, by faxing back the attached confirmation form, whether you have any changes or wish to add any to your recommendations. A hard copy will follow in the mail.

Thank you again for your help regarding this matter.

Sincerely,

Michael Shahnasarian, Ph.D.
President

MS/rb
Encl.

Dictated by Dr. Shahnasarian and signed in his absence to avoid delay.

Michael Shahnasarian, Ph.D.
11019 North Dale Mabry Highway
Tampa, FL 33618
813-265-9262 813-265-4226 FAX

CONFIRMATION FORM

DATE: ______________________________

FROM: Doctor Name

TO: Michael Shahnasarian, Ph.D.

FAX NO: (813) 265-4226

RE: - Life Care Plan - ______________________________

MESSAGE*:*

____ I have received the Life Care Plan prepared by Michael Shahnasarian, Ph.D., reviewed my recommendations, and have no changes to offer.

____ I have received the Life Care Plan prepared by Michael Shahnasarian, Ph.D., reviewed my recommendations, and suggest the following changes:

______________________________ ____________________

Signature ***Date***

Confidentiality Notice

The information contained in this facsimile message is legally privileged and confidential information intended only for use of the individual or entity names. If the reader to this message is not the intended recipient or an employee or agent of the addressee please do not read, use, disclose, copy or distribute this message. If you have received this facsimile in error please notify us immediately by telephone to arrange for its return.

Date ________

PATIENT:
DOB:
DOI:

Questions for Dr. for future care needs of Mr./Ms. Name

What, if any, current and future diagnostic evaluations (e.g., CT scan, x-rays, MRIs, EEG. EKG, NCV) do you recommend for Mr./Ms. Name because of injuries he/she sustained in him/her March 6, 2017, motor vehicle accident? Please specify schedules of any recurrent and serial diagnostic evaluations now and over the remainder of Mr./Ms. Name' life.

What, if any, current and future treatment do you recommend for Mr./Ms. Name (e.g., PT, OT, exercise program) because of injuries he/she sustained in him/her March 6, 2017, motor vehicle accident? Please specify treatment protocols, including the frequency and duration of each protocol – both now and in the future.

How frequently do you believe Mr./Ms. Name will require follow-up visits with you or another neurologist because of injuries he/she sustained in him/her March 6, 2017, motor vehicle accident? Please consider present and future protocols.

PATIENT:
DOB:

Questions for Dr. for future care needs of Mr./Ms. Name

Do you believe that Mr./Ms. Name would benefit from consultations and/or treatment with other specialists because of injuries he/she sustained in him/her March 6, 2017, motor vehicle accident? (eg pain management, orthopedic surgeon, etc)? Please specify specialists, along with frequency of office visits, and the duration of future treatment.

Do you believe that Mr./Ms. Name will most likely require ongoing prescriptions of medications because of injuries he/she sustained in him/her March 6, 2017, motor vehicle accident? Please delineate present and future prescriptions, including: name of medication, reason for prescription, dosage and duration.

Do you have any recommendations for current and/or future durable medical equipment or adaptive aids for Mr./Ms. Name because of injuries he/she sustained in him/her March 6, 2017, motor vehicle accident? Please consider current and future needs over Mr./Ms. Name' lifespan, indicating when the need for different types of durable medical equipment is anticipated.

PATIENT
DOB: 11/05/90

Questions for Dr. for future care needs of Mr./Ms. Name

What, if any, future surgeries will be required for Mr./Ms. Name to undergo because of injuries he/she sustained in him/her March 6, 2017, motor vehicle accident? Please specify the procedure(s), time frame, and post-operative care protocols.

Will Mr./Ms. Name require physical therapy or other specified treatment after each projected surgery, if any, because of injuries he/she sustained in him/her March 6, 2017, motor vehicle accident? Please specify treatment protocols.

Are there any other rehabilitation recommendations that you have for Mr./Ms. Name as you consider him/her medical future course because of injuries he/she sustained in him/her March 6, 2017, motor vehicle accident? Please specify treatment protocols, including when interventions are anticipated.