**Physical Form**

**Attention Physician:** All information must be completed; if not applicable, please state N/A.

|  |
| --- |
| Date of Exam: |

|  |  |
| --- | --- |
| Individual’s Name (Last, First, M)  | Date of Birth:  |
| Individual’s Address:   | Telephone #: (814)  |

Review of present and past health history: Including assessment of individual’s mental, emotional, and physical disability.

|  |  |  |
| --- | --- | --- |
| Info. Pertinent to diagnosis/treatments in emergency | Contraindicated meads | Allergies |
|  |  |  |
|  |  |  |

List of prescribed medications: Any special instructions regarding these medications, and schedule of individual self-administration of medication, if applicable.

SEE ATTACHED

|  |  |  |
| --- | --- | --- |
| Recommended modification/limitations for activities/exercise | Special Dietary Instructions | Sensory Aids |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| Vision (Acuity) | Hearing (Audiomelry/equiv.) | Blood Pressure |
| \_ Normal \_ AbnormalWith Corrective LensesR. 20/\_\_ L 20\_\_ | \_ Normal \_ NormalR. 15/\_\_ L14 | Blood Pressure \_\_\_\_\_\_\_\_\_\_\_ \_Normal \_ Abnormal |

|  |  |
| --- | --- |
| Growth MeasurementHeight \_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_lbs. Pulse \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Respiration | Need for Blood Work? \_ Yes \_ NoIf so, recommended tests and interval.  |

Immunizations: Are all immunizations up to date? (Tetanus/Diphtheria Immunizations are required for all individuals who are 18 years of age and older, every ten years.) \_\_ YES \_\_ NO

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Immunization | Date | Immunization | Date  | Immunization  | Date |
|  Pertussis |  | Trivalent Oral |  | Measles (15 Months or older |  |
| 1st (2 months) |  | Polio Vaccine |  | Rubella (15 Months or older |  |
| 2nd (4months) |  | 1st (2months) |  | Mumps (15 months or older |  |
| 3rd (6months) |  | 2nd (4months) |  | Diphtheria (10 and older) |  |
| Booster |  | 3rd (18 months) |  | Tetanus (18 and older) |  |
| Booser |  | 4th (4-6 years) |  |  |  |

(If out of date or unknown, please give recommended immunizations or include statement as to why they cannot be given)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medical | Normal | Describe Abnormality | Medical | Normal | Describe Abnormality |
| Eyes |  |  | Genitals / Breasts |  |  |
| Ears / Nose |  |  | Anal / Rectal |  |  |
| Mouth / Throat |  |  | Extremities / Joints |  |  |
| Lungs |  |  | Spine |  |  |
| Cardiovascular |  |  | Nervous System |  |  |
| Abdomen |  |  |  |  |  |

\*This section is required for CH, CLA, CRF, and FLP residents.

* **Gynecological and Pap Test** – annually required for women over 18.

 Results:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Mammogram** – Every two years for women 40 to 49; annually for woman 50 and over.

Results:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Prostate** – Annually for Men 40 and over.

Results:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Mantoux Test** (Required every two years; Tine Test is not acceptable)

Mantoux Test Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mantoux Test Read Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mantoux Test Results: \_\_ **Positive**  \_\_ **Negative** (Signature) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Chest X-ray, if positive:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hepatitis B Screening** – check if required: \_\_\_ Yes

 Results: \_\_ Negative \_\_ Positive \_\_ Active Carrier \_\_ Non Active Carrier

 Inoculation Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recommended further medical tests or examination on the following:**

\_\_ Vision \_\_ HGB \_\_ Hearing \_\_ Dental \_\_ Blood Pressure \_\_ Urinalysis

\_\_ Medical (Specify);\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Recommended Medication (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\***Instructions for health maintenance needs and use of medical treatment / therapies**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this patient free from communicable or infectious diseases? \_\_ Yes \_\_ No

If not, what precautions must be taken to prevent the spread of disease? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Health Care Providers Statement:*** I hereby certify that I have reviewed the current medical history accompanying this individual, examined him/her, and find him/her to be in good health with notable exceptions documented. This indiv. has a diagnosis of an Intellectual Disability and is recommended for ICF/ID (intermediate care facility) level of care.

Printed Name of Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physicians Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physicians Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_