# REPORT OF RESIDENT PHYSICAL EXAMINATION

**(Examination is to be completed by an independent physician within 30 days prior to the date of admission. Report is to be kept as part of the person's permanent record.)**

_____

**NAME** **DATE OF PHYSICAL EXAMINATION:**

**ADDRESS**

**TELEPHONE**

_____

**Height:** _____ **Weight:** _____ **BP:** _____

_____

**Significant Medical History:**

_____

_____

_____

_____

**General physical condition, including systems review as is medically indicated:**

_____

_____

_____

_____

_____

_____

**Allergies (food, medicine, or other):**

_____

_____

**Is this person:**

___ **Ambulatory (physically and mentally capable of self-preservation by evacuating in response to an emergency to a refuge area as defined by the Uniform Statewide Building Code without the assistance of another person, or from the structure itself without the assistance of another person if there is no such refuge area within the structure, even if such resident may require the assistance of a wheelchair, walker, cane, prosthetic device, or a single verbal command to evacuate).**

____ **Nonambulatory (by reason of physical or mental impairment is not capable of self-preservation without the assistance of another person).**

**Does this individual have any of the following conditions or care needs?** **Name** _____

| Condition/Care Need | Yes | No | Comment |
|---|---|---|---|
| Ventilator dependency | | | |
| Dermal ulcers III and IV | | | If stage III is ulcer healing? |
| Intravenous therapy or injections directly into the vein | | | If intermittent therapy please note and indicate expected time period. |
| Airborne infectious disease in a communicable state that requires isolation or special precautions to prevent transmission | | | |
| Psychotropic medications without appropriate diagnosis and treatment plans | | | |
| Nasogastric tubes | | | |
| Gastric tubes | | | If yes, is person capable of independently feeding himself and caring for the tube? |
| Presents imminent physical threat or danger to self or others | | | |
| Requires continuous licensed nursing care | | | |

Name _____

**Diagnosis or significant problems:**

_____

_____

_____

_____

_____

_____

**Recommendations for care:**

**Medications:**

_____

_____

_____

_____

_____

**Diet:** _____

_____

_____

_____

**Therapy:** _____

_____

_____

_____

**Signature:** _____ **Date:** _____

_____
**(Please print or type physician's name here)**

**Address (Street, City, State, Zip Code)**

_____ **Telephone:** _____

**ATTACHMENT I**

# REPORT OF TUBERCULOSIS SCREENING EVALUATION

**Name** _____ **Birthdate** _____/_____/_____

**Address** _____

_____

1. **Date and result of most recent Mantoux tuberculin skin test: Date: _____/_____/_____**
   **mm of induration _____**

2. **Check here if previously positive and above information unknown _____**

3. **Check here if exhibiting TB-like symptoms _____**

4. **If TB skin test is 10 mm or greater (5mm in the HIV infected), previously positive or if TB-like symptoms exist, *respond to the following:***

   a. **Date of last chest x-ray evaluation: Date: _____/_____/_____**

   b. **Is chest x-ray suggestive of active TB? *(circle one)* YES NO**

   c. **Were sputum smears collected and analyzed for the presence of Acid Fast Bacilli (AFB)? *(circle one)* YES NO**

   d. **If 4c is YES, were three consecutive smears negative for AFB? *(circle one)* YES NO**

5. **Based on the above information, is this individual free of communicable TB? *(circle one)* YES NO**

6. **Name of licensed physician, physician's designee or local health department official completing the evaluation:**

   _____ _____
   ***Print Name*** ***Phone***

7. **Signature of license physician, physician's designee or local health department official completing evaluation:**

   _____ _____/_____/_____
   ***Date***

**032-05-419 (8/99)**