CARING PROFESSIONALS, INC.

PHYSICAL EXAMINATION
(1)

NAME:_____RN/LPN/HHA/PCA

ADDRESS:_____SOCIAL SECURITY#
_____--_____--_____

_____

PHONE:_____ **TODAY'S DATE**_____

****

I. Past Medical/Psychological History

Tuberculosis: no ( ) yes ( )
Diabetes: no ( ) yes ( )
Heart or Cardiovascular Disease: no ( ) yes ( )
Hypertension: no ( ) yes ( )
Cancer: no ( ) yes ( )
Kidney Disease: no ( ) yes ( )
Allergies: no ( ) If yes , state: _____
Epilepsy or seizure disorder: no ( ) yes ( )
Drug alcohol abuse or addiction: no ( ) yes ( )
Psychiatric or Behavioral Disorder: no ( ) yes ( )
Other:_____
Are you now taking medications? If so, for what?_____

_____

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EXAMINER: PLEASE COMPLETE THE FOLLOWING:
II. **Mandatory** Immunizations and Lab tests.
Exact titre number must be given as requested.

PPD (MANTOUX) DATE GIVEN_____ DATE READ_____
RESULTS: NEGATIVE _____mm POSITIVE _____mm
MANUFACTURER _____ LOT#_____
2nd STEP PPD DATE GIVEN_____ DATE READ_____
RESULTS: NEGATIVE _____mm POSITIVE _____mm
MANUFACTURER_____ LOT#_____
(History of positive PPD must be documented above. We cannot accept a chest x-ray without proof of +PPD)

Alternative to PPD testing: WHOLE BLOOD ASSAY TEST FOR T.B. (please attach the actual report not just the summary interpretation)
DATE DRAWN: _____

RESULTS: _____ (NEGATIVE/POSITIVE)

CHEST X-RAY (MANDATORY ***ONLY*** IF PPD/blood assay IS POSITIVE) DATE: _____
RESULTS:_____

RUBELLA TITRE:_____DATE_____
RESULTS: ( ) IMMUNE ( ) NOT IMMUNE
RUBELLA VACCINE (IF NEEDED) :_____

RUBEOLA (not needed if born before 1957) TITRE:_____ DATE_____
RESULTS: ( ) IMMUNE ( ) NOT IMMUNE
RUBEOLA VACCINE: 1st _____, 2nd _____

VARICELLA TITRE: _____ DATE _____
RESULTS: ( ) IMMUNE ( ) NOT IMMUNE
IF NOT IMMUNE: VACCINATION REFUSED ( ) CONTRAINDICATED ( )
VACCINE DATES: 1ST _____, 2ND _____

CARING PROFESSIONALS, INC.

PHYSICAL EXAMINATION
(2)

HEPATITIS B: ( ) IMMUNE ( ) REFUSAL ( ) IMMUNIZATION CONTRAINDICATED
VACCINE DATES:_____, _____, _____

NAME: _____

III. LAB TESTS

	RESULTS	DATE
URINALYSIS	_____	_____
CBC	_____	_____
DRUG SCREEN	_____	_____

IV. REVIEW OF SYSTEMS BY EXAMINER:

Head/Neck_____

EENT_____

Resp._____

Cardiovasc._____

Abd - GI_____

GU_____

Musc - skel_____

Neuro_____

Endocrine_____

Skin_____

Height_____Weight_____
****

V. MEDICAL EXAMINER:

I hereby certify that the above named patient does not have any limitations for employment in the health care field, and contact with patients and other staff. There is no health impairment present that is of potential risk to the employee, patient, family, or other employees, or that may interfere with the performance of duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

PHYSICIAN'S SIGNATURE_____

PHYSICIAN'S NAME (PRINT)_____

Address:_____Phone:_____

(PLEASE USE PHYSICIAN'S STAMP)

CARING
PROFESSIONALS, INC
"Caring Professionals...Professionals Who Care"

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Forest Hills, NY 11375

(718) 897- CARE
(718) 897-2273
Fax (718) 897-0428

PRE-HIRE TUBERCULOSIS RISK ASSESSMENT

NAME: _____ **TITLE:** _____

Please review and answer the following questions with the individual above:

1. Have you had a history of a temporary or permanent residence (for ≥1 month) in a country with a high TB rate (i.e., any country other than Australia, Canada, New Zealand, the United States, and those in Western or Northern Europe)?
   Yes: _____ No: _____
   If yes, when _____

2. Do you have a current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with a tumor necrosis factor (TNF) -alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month), or other immunosuppressive medication?
   Yes: _____ No: _____

3. Have you had close contact with someone who has had infectious TB disease since your last TB test? Yes:_____ No: _____
   a. If yes, when? _____
   b. Did you have adequate personal protection when exposed?_____

4. Have you had a prior bacille Calmette-Guerin (BCG) Vaccination?
   Yes: _____ No: _____
   a. If yes, when? _____

5. Have you ever been diagnosed with Latent TB infection (LTBI)?
   Yes _____ No _____
   a. If yes, when? _____

6. Have you ever been treated for Latent TB infection (LTBI)? Yes: _____ No:_____
   a. If yes, when? _____

7. Have you ever been diagnosed with TB infection (TB)? Yes: _____ No: _____
   a. If yes, when? _____

8. Have you ever been treated for TB infection (TB)? Yes: _____ No: _____

a. If yes, when? _____

9. Have you had any prior diagnostic testing for TB disease? Yes: ____ No: _____
   a. If yes, when? _____

10. Have you ever had a tuberculin skin test (TST)?
    a. Yes _____ No _____
    b. If yes When_____ Result_____

11. When was your last chest x-ray?
    a. Date_____ Result_____
    b. Never had a chest x-ray done _____

12. Do you currently have any of the following symptoms?

Productive cough for more than 3 weeks	Yes_____	No_____
Coughing up blood	Yes_____	No_____
Unexplained weight loss	Yes_____	No_____
Fever, chills, or drenching night sweats for no known reason	Yes_____	No_____
Persistent shortness of breath	Yes_____	No_____
Unexplained fatigue for more than 3 weeks	Yes_____	No_____
Chest Pain	Yes_____	No_____

COMMENTS: _____
_____
_____
_____
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COMPLETED AND REVIEWED BY:

NAME: _____ MD, RN, PA, NP

SIGNATURE _____

DATE: _____

FOLLOW UP NOT REQUIRE/CLEARED TO WORK _____

FOLLOW UP REQUIRED _____