Spark 2 Hope

A Spark of Possibilities

ANNUAL PHYSICAL EXAMINATION

Name:_____ Date: _____

Referred to (licensed health care professional): _____

Level of supervision (staff to client ratio):

☐ 1:1 ☐ 1:3 ☐ 1:5

Details:_____

DOB:_____ Allergies:_____ Diet:_____

Diagnoses:_____

_____

Current medications and doses (attach med list as necessary): Purpose:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Current treatments (attach orders as necessary): Purpose:

_____ _____

_____ _____

_____ _____

_____ _____

Health concerns:

_____

_____

_____

EXAMINATION RESULTS:

The annual physical assessment is to include a physical examination, hearing and vision screening, CBC, urinalysis, chest x-ray or Mantoux, pap smear, and a review of the medical treatment plan.

Height:_____ Weight:_____ Ideal Weight Range:_____

Temp.:_____ Pulse:_____ Blood Pressure:_____

Review of Systems:

Skin:_____ Lymph Nodes:_____

Eyes: (R)_____ (L)_____ Ears: (R)_____ (L)_____

Nose:_____ Throat:_____ Mouth:_____

Neck:_____ Lungs:_____

Heart:_____ Breasts:_____

Abdomen:_____ Extremities:_____

Genito-Urinary:_____ Ano-Rectal:_____

Posture:_____ Gait:_____

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Elk River, Minnesota 55330

Nervous System:_____
Fine Motor:_____ Gross Motor:_____
Note any physical abnormality:_____

Are there any medical or psychological contraindications to the use of staff implemented manual restraint to protect this person, when a person's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety? ☐ Yes ☐ No

If yes, what are they and are there any special adaptations or precautions staff may take to still use manual restraint in dangerous circumstances (list on next page)?

_____
_____

Vision Screening: Results:_____
Is a more thorough vision exam recommended? ☐ Yes ☐ No

Hearing Screening: Results:_____
Is a more thorough audiology exam recommended? ☐ Yes ☐ No

Note any problems with speech and language:_ _____
_____
Is referral to a speech/language therapist indicated? ☐ Yes ☐ No

Laboratory Data: The following lab tests are requested, please attach copies of all results:

	Date Administered	**Notes/Results:** If test not administered, please list rationale
Cholesterol		
A1-C		
LFT		
CBC		
Urinalysis		
Mammogram		
Pap Smear		
Other:_____		

Chest x-ray or Mantoux given: _____ Location of Mantoux:_____
Date read:_____ Results:_____

Diphtheria-Tetanus shot given? ☐ Yes ☐ No Date of last Diphtheria-Tetanus shot: _____

I find this individual to be free of communicable disease: ☐ Yes ☐ No

General health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Summary of exam and diagnosis:

_____
_____
_____

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Treatment plan (new orders):

_____

_____

Medications (new orders):

_____

Is individual capable of administering own medications? ☐ Yes ☐ No

Please Note:

1. All medications and treatments will be ordered for 1 year unless stop and start dates are indicated.
2. Your signature indicates you have reviewed these findings with the person/staff present.
3. Please provide instruction on when and to whom to report the following:
   a. Occurrence of adverse reactions to medications or treatments
   b. Medication not being administered or treatment performed as prescribed, whether by error of staff or refusal by the person
   c. Report to and when:

      _____

      _____

      _____

      _____

Please call medication changes to our pharmacy _____

Phone:_____ Fax:_____

Physician signature: _____ Date: _____

Reviewed by: _____ Date: _____

Staff signature

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