P.O. Box 84 Fort Atkinson, WI 53538 (920) 563-8554 office (920) 563-8558 fax

http://abilitiesinc.us

Physical Examination Form

Consumer Name:_____ Date:_____

- Check if this is an initial exam following admission
- Check if orders are needed

Physician Information:

Name:_____ Phone:_____

Address:_____ Fax:_____

Age:_____ Weight:_____ Height:_____

Blood Pressure:_____/_____ Respiration:_____/min Pulse:_____

- Medication List is attached to this form
- Check if you need refills for prescriptions

Systems Review

HEENT:_____

Cardiac:_____

Respiratory:_____

GI:_____

GU:_____

Musculoskeletal:_____

Central Nervous System:_____

Physical Exam

- Check if physician is providing dictation of this exam
- Check if a visit summary will be printed off and attached to this form

General Appearance (physical and mental status):_____

_____

_____

HEENT:_____

Neck:_____

Chest/Lungs:_____

Heart:_____

Breasts:_____

Abdomen:_____

GU:_____

Rectal/Pelvic:_____

Skin:_____

Musculoskeletal/Extremities:_____

Neurological/Sensorimotor:_____

Motor Functions:_____

Coordination:_____

Reflexes:_____

Involuntary Movements:_____

Speech/Language:_____

Certification of Communicable Diseases and Vaccination Status

Last Tetanus:_____

Hep B Vaccine:_____

Flu Shot:_____

Pneumovax:_____

TB Skin Test: Placed:_____ Read:_____

Results:_____

Chest X-Ray:_____

POCare/Orders:_____

_____

_____

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_____

*** Orders do not replace prescriptions. All prescriptions are to be called into the Pharmacy or sent electronically. By sending any orders to McCullough's Pharmacy all Abilities staff that have completed and passed a DHS approved Medication Administration class are permitted to administer medications for the resident listed on this physical form. Your signed orders will act as this permission.

Certification of Communicable Disease Statement:

By signing below, I certify this individual to be free of communicable diseases based on testing and a physical evaluation of their health.

_____ _____

Physician Signature Date