**TRI-MED HOME CARE SERVICES, INC.** **EMPLOYEE PHYSICAL EXAMINATION REPORT**

**PHONE: (347) 727-7200 FAX: (347) 926-4709**

 Pre-Employment Physical Assessment  Annual Assessment  Return to work/LOA  Other:

|  |  |  |
| --- | --- | --- |
| **Name:** | Marital Status: M S W D | Sex: M F |
| **Address:** | **Social Security#** | Title: |
| **PHYSICAL EXAMINITATION** |
| HEAD/ENT: |
| EYES: |
| NECK: |
| BREASTS: |
| LINGS: |
| CARDIOVASCULAR: |
| MUSCULOSKELETAL: |
| ABDOMEN: |
| GENITOURINARY: |
| CENTRAL NERVOUS SYSTEM: |
| COMMENTS |
| **HT:** | **WT:** | **B/P:** | **PULSE:** | **RESP:** | **TEMP:** |
| **LABORATORY TEST RESULTS** |
| **TEST** | **DATE PERFORMED** | **RESULTS** Provide lab values and interpretation |
| RUBELLA TITER |  | NON-IMMUNE IMMUNE LAB VALUE: |
| MEASLES TITER |  | NON-IMMUNE IMMUNE LAB VALUE: |
| PPD (ANNUALLY) | 1 DATE IMPLANTED | 1 DATE READ | RESULTS (mm/mm): |
|  | 2 DATE IMPLANTED | 2 DATE READ | RESULTS (mm/mm): |
| CHEST X-RAY (+PPD) | DATE: | RESULTS: |
| **IMMUNIZATIONS:** | **DATE** | **DATE** | **DATE** |
| RUBELLA | 1. |  |  |
| RUBEOLA/MEASLES | 1. | 2. |  |
| HEPATITIS B VACCINE (Optional) Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_FLU VACCINE Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_ | 1. |  |  |
| DRUG SCREEN (**8 PANEL**) LAB WORK MUST BE ATTACHED |  |  |  |

 **This individual is free from any health impairment that is a potential risk to the patient or other employees or which may interfere with the performance of his/her duties including habituated or addicted to any depressants, stimulants, narcotics, drugs, alcohol or other substances that may alter behavior.**

 **This individual is able to work with the following limitations:**

**OFFICE STAMP:**

 **This individual is not physically/mentally able to work (specify reason):**

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lic. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_