**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_