Rockaway Home Care

Physical Examination

☐ Pre-Employment Physical	☐ Return to Work / LOA	☐ Annual
Name:	Marital Status:	Sex: ☐ Male ☐ Female
Address:	SS#:	DOB:

Physical Examination					
Head/ENT:					
Eyes:					
Neck:					
Breasts:					
Lungs:					
Cardiovascular:					
Musculoskeletal:					
Abdomen:					
Genitourinary:					
Central Nervous System:					
Comments:					
HT:	WT:	B/P:	Pulse:	Resp:	Temp:

Please Send Copy of Laboratory Results			
Test	Date Preformed	Results – Provide Lab Values and Interpretation	
Rubella Titer			
Measles Titer			
PPD (New Hire)	1. Date Implanted 2. Date Implanted	1. Date Read 2. Date Read	1. Results (mmxmm) 2. Results (mmxmm)
QuantiFeron (TB-Gold)			
Chest X-Ray (+PPD)			
Drug Screen			

Immunizations	Date		
Rubella	1.		
Rubella / Measles	1.	2.	
Hepatitis B Vaccine	1.	2.	3.
Other	1.	2.	3.

☐ This individual is free from any health impairment that is a potential risk to the patient or other employee or which may Interfere with the performance of his/her duties including the habituation or addiction to drugs or alcohol.

☐ This individual is able to work with the following limitations:

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

Tuberculosis Risk Assessment

Any history of 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

Any current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with an TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone >15mg/day for >1 month) or other immunosuppressive medication? ☐ Yes ☐ No

Any close contact with someone who has had TB disease? ☐ Yes ☐ No

Past treatment for latent TB infection? ☐ Yes ☐ No

Symptom screening:

- Productive cough for more than 3 weeks ☐ Yes ☐ No
- Coughing up blood; • 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

Any prior diagnosis of active TB or latent TB infection or a positive skin test or positive blood test for TB? ☐ Yes ☐ No

Past treatment with medication for TB or for a positive TB test? ☐ Yes ☐ No

Physician Stamp:	Physicians Signature:	
	Lic #:	
	Phone #:	Date: