



Carelink Health Care Services, LLC

INITIAL PHYSICAL EXAMINATION FORM

(To be filled out by Physician)

NAME: _____ DATE OF EXAM: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

ADDRESS: _____

PAST HISTORY: (Significant Illnesses/Hospitalization)

RECENT IMMUNIZATIONS: (Within past 10 years)

PHYSICAL EXAMINATION:

HEIGHT: _____ VISION: _____ HEART: _____

WEIGHT: _____ HEARING: _____ LUNGS: _____

BLOOD PRESSURE: _____ SKIN: _____ ABDOMEN: _____

IS INDIVIDUAL FREE FROM COMMUNICABLE DISEASES? Yes ☐ No ☐ (If no, explain)

WILL THIS DISEASE INTERFERE WITH THE HEALTH OF INDIVIDUALS RECEIVING CARE IN THEIR RESIDENT OR COMMUNITY BASED FACILITY? Yes ☐ No ☐

ARE THERE ANY OTHER CONDITIONS YOU FEEL WOULD ADVERSELY AFFECT INDIVIDUAL RECEIVING CARE OR WOULD ADVERSELY AFFECT OTHER STAFF MEMBERS? Yes ☐ No ☐

ARE THERE ANY OTHER CONDITIONS YOU FEEL WOULD ADVERSELY AFFECT THIS INDIVIDUAL IN CARRYING OUT HIS/HER DUTIES IN A RESIDENTIAL OR COMMUNITY-BASED FACILITY? Yes ☐ No ☐

☐ Rubella Screening ☐ POS ☐ NEG | Date Tested _____ ☐ Rubeola Screening ☐ POS ☐ NEG | Date Tested _____

Complete IGRA Blood Test or 2-Step Mantoux Test

☐ IGRA blood test Date IGRA Test Completed _____ Positive ☐ Negative ☐

RESULT OF TUBERCULIN TWO-STEP TEST (Mantoux Method Required)

Positive ☐ Negative ☐ Date Tuberculin Test Placed _____ Date Tuberculin Test Read _____

Positive ☐ Negative ☐ Date Tuberculin Test Placed _____ Date Tuberculin Test Read _____

IF POSITIVE SKIN TEST, RESULT OF CHEST X-RAY:

Positive ☐ Negative ☐ Date of X-ray _____ Asymptomatic History _____

RESULT OF HEPATITIS SCREEN:

Positive ☐ Negative ☐ Date of Test _____ Hepatitis B Declination ☐ Employee Sign: _____

Physician's Name (Print)

Physician's License Number

Physician's Signature

Physician's Telephone Number