Today's Homecare, Inc.
2575 East 14 Street, Unit C1, Brooklyn, NY 11235
Phone: 718-650-3558 | Fax: 855-289-2365
www.TodaysHC.com | Info@TodaysHC.com

Уведомляем Вас о том, что действие Вашего медицинского обследования истекает.
В соответствии с требованием "Department of Health" и компании Today 's Homecare, Inc., Вы обязаны пройти годовое медицинское обследование за 2 недели до истечения срока действия. В противном случае Вы будете отстранены от работы до тех пор, пока мы не получим форму Вашего Ежегодного физического осмотра. **Ежегодный физический осмотр должен быть заполнен и подписан сотрудником ТОЛЬКО на форме "Today's Homecare, Inc".**

В связи с этим, Вы должны предоставить:

- ☐ Общее медицинское обследование - Подпись сотрудника
- ☐ Annual Tuberculosis (TB) Risk Assessment Form – Подпись MD/RN/PA/NP

Вы должны пройти Ежегодный физический осмотр бесплатно по телефону: "NY Best Medical CARE" - 718-972-3693.

Please be advised, that your physical will expire soon.
By the DOH requirement and Today's Homecare, Inc., policies, and procedures, the required annual physical must be completed 2 weeks prior of the expiration date. Otherwise, you will not be able to continue working until we receive your up-to-date medical examination forms. **Annual Physical Assessment must be completed by the employee and signed on Today's Homecare, Inc form ONLY.**

You are required to do:

- ☐ Annual Physical Assessment – Sign by employee only
- ☐ Annual Tuberculosis (TB) Risk Assessment Form. - Sign by MD/RN/PA/NP

You can do your Annual TB Risk Assessment FREE of charge at "NY Best Medical PC" over the phone - 718-972-3693.

De acuerdo con nuestros registros, su evaluación física anual se expirará pronto.
Segun los requisitos de el Departamento de Salud, un físico actualizado es necesario anualmente, y tiene que ser actualizado 2 semanas antes de expirarse. De lo contrario somos obligados a terminar su travajo asta que pueda proveer el nuevo fisico. **La evaluación física anual debe ser completada SOLAMENTE en el formulario "Today's Homecare, Inc".**

Debe hacer:

- ☐ Evaluación física anual: (Solo debe firmar el empleado)
- ☐ Formulario anual de Evaluación del Riesgo de Tuberculosis (TB). – (Firmado por un medico o enfermera)

Si necesita hacer su Evaluacion del Riesgo de Tuberculosis, llame por teléfono a "NY Best Medical PC" - 718-972-3693.

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PHYSICAL EXAMS

NY BEST MEDICAL CARE P.C.

No appointments necessary

503 Ditmas Ave
Brooklyn, NY 11218
Tel (718) 972-3693

3000 Ocean Parkway,
Brooklyn, NY 11235
Tel (718) 283-4444

391 East 149th Street, Ste 305, Bronx, NY 10455
Tel (718) 972-3693

www.nybestmedical.com

HOME CARE (HHA, PCA, CDPAP)
CORONA VIRUS (COVID-19 & ANTYBODY TESTING)
FREE CORONA VIRUS TESTING TO UNINSURED

FULL EXAMINATION (PHYSICAL, TB TESTING, TITERS, VACCINES, CHAIN OF CUSTODY DRUG TEST, X-RAY REFERRAL – IF REQUIRED)

COMPLETED PHYSICAL FORMS
FLU SHOTS

TELEHEALTH SERVICES
WE COMPLETE DOH FORMS, M11Q, FACE TO FACE ENCOUNTER FORMS WITHIN 24 HOURS

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ANNUAL PHYSICAL ASSESSMENT

Employee Name: _____ ID# _____ Date: _____

This annual physical assessment is not intended to be a complete physical examination, nor to replace medical care by your own physician. This is to certify, that to the best of my knowledge, there is no health impairment present that is of potential risk to me, patient, family or other employees, or that may interfere with the performance of my duties.
I certify that I am free from habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter my behavior.
I understand that any falsification or misrepresentation of medical facts will be sufficient grounds for my release from employment.

Employee Signature: (Подпись): _____

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Within the past **12 months** have you had:

CONDITION	YES	NO	CONDITION	YES	NO
Surgery			Digestive Problems		
Fractures			Diabetes		
Disabling Injury			Loss of Weight		
Hernia			Arthritis		
Chronic back pain/injury			Have you noticed lumps or nodules in your breast?		
Fainting Spells			Problem with habituation or addiction to alcohol, depressants, stimulants, narcotics or other substances that may alter behavior		
Seizures			Are you or have you been restricted in the kind or amount of work you do?		
Mental Illness			Have you been treated for an infectious condition?		
Chronic Coughing			Are you being treated for a medical condition?		
Asthma-Allergies					

Explanation of "YES" answers: _____

_____

_____

Referral for follow-up: YES: ☐ NO: ☐ (if yes, state details): _____

_____

Reviewed by: _____, RN Date: _____

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ANNUAL TUBERCULOSIS RISK ASSESSMENT

Employee Name: _____ Title: _____

Please review and answer the following questions with the individual above:

1. Have you had a 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) **in the past year**?
   Yes: ☐ No: ☐ If yes, when: _____
2. Do you have a current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with a tumor necrosis factor (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: ☐
3. Have you had close contact with someone who has had infectious TB disease **in the past year**? Yes: ☐ No: ☐
   If yes, when? _____ b. Did you have adequate personal protection when exposed? _____
4. Have you ever been diagnosed with Latent TB infection (LTBI)? Yes: ☐ No: ☐
   If yes, when? _____
5. Have you ever been treated for Latent TB infection (LTBI)? Yes: ☐ No: ☐
   If yes, when? _____
6. Have you ever been diagnosed with TB infection (TB)? Yes: ☐ No: ☐
   If yes, when? _____
7. Have you ever been treated for TB infection (TB)? Yes: ☐ No: ☐
   If yes, when? _____
8. Have you had any prior diagnostic testing for TB disease? Yes: ☐ No: ☐
   If yes, when? _____ Result _____
9. Have you ever had a tuberculin skin test (TST)? Yes: ☐ No: ☐
   If yes, when? _____ Result _____
10. When was your last chest x-ray?
    Date: _____ Result_____

    Never had a chest x-ray done _____
11. Do you currently have any of the following symptoms?

Productive cough for more than 3 weeks	Yes: _____ No: _____
Coughing up blood	Yes: _____ No: _____
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: _____

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COMPLETED AND REVIEWED BY:

NAME: _____ MD/RN/PA/NP

Signature: _____Date: _____/_____/_____

FOLLOW UP NOT REQUIRE/CLEARED TO WORK _____

FOLLOW UP REQUIRED _____