TODAY'S HOMECARE, INC.
2575 East 14 Street, Brooklyn, NY 11235
Phone: 718-650-3558 | Fax: 855-289-2365
www.TodaysHC.com | Info@Todayshc.com

PHYSICAL EXAMINATION

Last Name: _____ **First Name:** _____

ADDRESS: _____

PHONE: _____ **CELL PHONE:** _____

I. Past Medical/Psychological History

CONDITION	YES	NO	CONDITION	YES	NO
Tuberculosis			Kidney Disease		
Diabetes			Allergies (if yes, state)		
Heart or Cardiovascular Disease			Epilepsy or seizure disorder		
Hypertension			Drug alcohol abuse or addiction		
Cancer			other		

Are you now taking medications? If so, please list: _____

II. **Mandatory** Immunizations and Lab tests. **Exact titre number must be given as requested**.

PPD (MANTOUX) DATE GIVEN: _____ **DATE READ:** _____
RESULTS: NEGATIVE: _____**mm** **POSITIVE:** _____**mm**
2nd STEP PPD **DATE GIVEN:** _____ **DATE READ:** _____
RESULTS: NEGATIVE: _____**mm** **POSITIVE:** _____**mm**

Alternative to PPD testing: WHOLE BLOOD ASSAY TEST FOR T.B.
DATE DRAWN: _____RESULTS: _____ (NEGATIVE/POSITIVE)

CHEST X-RAY (MANDATORY ***ONLY*** IF PPD/blood assay IS POSITIVE) DATE: _____ RESULTS: _____

III.

RUBELLA: TITRE_____ IMMUNE ☐ NOT IMMUNE ☐	RUBEOLA (not needed before 1957): TITRE _____ IMMUNE: ☐ ; NOT IMMUNE: ☐
RUBELLA VACCINE (if needed) _____	RUBEOLA VACCINE: 1_____ 2_____
DRUG SCREEN: DATE: _____ RESULT_____ (please attach lab)	

IV. REVIEW OF SYSTEMS BY EXAMINER:

HEAD/NECK		MUSC-SKEL	
EENT		NEURO	
RESP		ENDOCRINE	
CARDIOVASC		SKIN	
ABD-GI		GU	
HEIGHT		WEIGHT	

V. MEDICAL EXAMINER:

I hereby certify that the above-named patient does not have any limitations for employment in the health care field and contact with patients and other staff. There is no health impairment present that is of potential risk to the employee, patient, family, or other employees, or that may interfere with the performance of duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

PHYSICIAN'S NAME

(PRINT)_____

PHYSICIAN'S SIGNATURE_____ DATE: _____

ADDRESS: _____ PHONE: _____

(PLEASE USE PHYSICIAN'S STAMP)

TODAY'S HOMECARE, INC.
2575 East 14 Street, Brooklyn, NY 11235
Phone: 718-650-3558 | Fax: 855-289-2365
www.TodaysHC.com | Info@Todayshc.com

PRE-HIRE 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)?
   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 since your last TB test? Yes: ☐ No: ☐
   If yes, when? _____ b. Did you have adequate personal protection when exposed? _____
4. Have you had a prior bacille Calmette-Guerin (BCG Vaccination?) Yes: ☐ No: ☐
   If yes, when? _____
5. Have you ever been diagnosed with Latent TB infection (LTBI)? Yes: ☐ No: ☐
   If yes, when? _____
6. Have you ever been treated for Latent TB infection (LTBI)? Yes: ☐ No: ☐
   If yes, when? _____
7. Have you ever been diagnosed with TB infection (TB)? Yes: ☐ No: ☐
   If yes, when? _____
8. Have you ever been treated for TB infection (TB)? Yes: ☐ No: ☐
   If yes, when? _____
9. Have you had any prior diagnostic testing for TB disease? Yes: ☐ No: ☐
   If yes, when? _____ Result: _____
10. Have you ever had a tuberculin skin test (TST)? Yes: ☐ No: ☐
    If yes, when? _____ Result: _____
11. When was your last chest x-ray?
    Date: _____ Result: _____

    Never had a chest x-ray done _____
12. 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: _____

==========

COMPLETED AND REVIEWED BY:

NAME: _____ MD/RN/PA/NP

Signature: _____Date: _____/_____/_____

FOLLOW UP NOT REQUIRE/CLEARED TO WORK _____

FOLLOW UP REQUIRED _____

TODAY'S HOMECARE, INC.
2575 East 14 Street, Brooklyn, NY 11235
Phone: 718-650-3558 | Fax: 855-289-2365
www.TodaysHC.com | Info@Todayshc.com

Attention Doctors:

It is our company policy that all individuals employed in our company have an annual complete physical. Complete physicals are to include the following:

1. **Complete Physical Examinations Form**

2. **Two Steps PPD testing or Quantiferon (Lab Results) -Pre-Employment Only**
(If PPD is Positive, a copy of Chest X-Ray results should be attached)

3. **Tuberculosis Screening Questionnaire and General Risk Checklist Assessment for TB must be signed by doctor and Employee.**

4. **Drug Screen (with Lab Report should be attached)**

5. **Rubella, Rubeola & Varicella IGG (Titer with Lab Report should be attached)**

Please note that we need copies of **ALL LAB WORK/REPORTS.**
All paperwork **must** include **DOCTOR'S SIGNATURE & STAMP.**

Sincerely,
HR Department