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:	
MUMPS		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:**

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

Physician's Signature: _____

Lic. # _____ Date: _____

OFFICE STAMP: