Fax: (718) 691-4670

PCA, HHA

PHYSICAL EXAMINATION REPORT

Name		DOB		Gender: ☐ M ☐ F ☐ Other	
Address		Phone		Last 4-digits SSN	

Physical Examination: ☐ Pre-Employment ☐ Annual Examination

	Comments		Comments
HEAD		ABDOMINAL	
EYES		EXTREMITIES	
NECK		CARDIOVASCULAR	
THROAT		MUSCULOSKELETAL	
LUNGS		SKIN	
HEART		CENTRAL NERVOUS SYSTEM	

HT:	WT:	B/P:	PULSE:	RESP:	TEMP:

Tuberculosis Skin Testing (PPD Skin Testing)
(PPD or QuantiFERON is required annually)

PPD	Date Implemented:	Date Read:	Results (mm): ☐ Positive ☐ Negative
QuantiFERON TB Blood Test (LAB REPORT REQUIRED)		Date:	Results: ☐ Positive ☐ Negative
Chest X-Ray (For + PPD Only) (LAB REPORT REQUIRED)		Date:	Results: ☐ WNL (Within-Normal Limits) ☐ Abnormal Findings

Since your last Annual Health Assessment, have you developed an addiction or habituation to alcohol, drugs or any other behavior altering substance that may interfere with the performance of your job duties or that poses a potential risk to the consumer?

☐ Yes ☐ No If “Yes”, please explain below:

____

____

Immunizations
(Lab reports required)

RUBELLA	Date Implanted:	☐ Non-Immune ☐ Immune Lab Value: ☐ MMR Vaccine Date:
RUBEOLA (MEASLES)	Date Implanted:	☐ Non-Immune ☐ Immune Lab Value: ☐ MMR Vaccine Date:
HEPATITIS B	Date Implanted:	Lab Value:
Drug Screen	Date Collected:	Result: ☐ Positive ☐ Negative

Influenza Vaccine
(If you decline, sign “Influenza Declination Form”)
A Seasonal Influenza Vaccination is Required Annually

INFLUENZA VACCINE: ☐ PROVIDED ☐ DECLINED	Date:

Physician’s Signature: ____________________________ Date: ____________________

Physician’s Stamp: ______________________________ License #: __________________

718-424-4200 • www.candthomecare.com • aideregistration@candthomecare.com
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DECLINATION OF INFLUENZA VACCINATION FOR HEALTH CARE PERSONNEL

Employee's Name: ____

Employee's ID#: ________________________

I have been advised that I should receive the influenza vaccine to protect myself and the patient(s) I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have had any questions answered by a healthcare provider. I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare personnel to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection changed almost every year, and even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this healthcare facility, coworkers, my family, and my community.
- **Because I have refused vaccination against influenza, I will be required to wear surgical or procedure masks in area where patients or residents may be present during the influenza season.**

I acknowledge that I have read this document in its entirety and fully understand it. Despite these facts, I have decided to decline the influenza vaccine as evidenced by my signature below. I realize that I may re-address this issue at any time and accept vaccination in the future.

Signature: ______________________________ Date: ____________

Witness: ______________________________ Date: ____________

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TUBERCULOSIS SCREENING QUESTIONNAIRE

Name: ______________________________ DOB: ______________

Positive TB Skin Test (PPD) Date: ______________ Result (mm): __________

Last Chest X-Ray Date: ____________________

Please indicate if you have been experiencing any of the following issues for three to four weeks or longer:

1.	Chronic Cough (greater than 3 weeks)	Yes ☐	No ☐
2.	Production of Sputum	Yes ☐	No ☐
3.	Blood-Streaked Sputum	Yes ☐	No ☐
4.	Unexplained Weight Loss	Yes ☐	No ☐
5.	Fever	Yes ☐	No ☐
6.	Fatigue/Tiredness	Yes ☐	No ☐
7.	Night Sweats	Yes ☐	No ☐
8.	Shortness of Breath	Yes ☐	No ☐

☐ NO EVIDENCE OF PULMONARY TUBERCULOSIS OR CONTAGIUM.

______________________________ ____________________

Health Care Provider (M.D., D.O., N.P.) License #

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Date

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