| Organization Name: | | | | | | | | | | | | Program Name: | | | | | | | | | | | | | Date: | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Individual’s Name (First MI Last): | | | | | | | | | | | | | | | | | | Record #: | | | | | | | DOB: | | | | | |
| **Part A**  **Brief Medical Screening** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Doctor’s Name: | | | | | | | Address: | | | | | | | | | | | | | | Phone Number: | | | | | **Date of Last Exam**: | | | | |
| Dentist’s Name: | | | | | | | Address: | | | | | | | | | | | | | | Phone Number: | | | | | **Date of Last Exam**: | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Has a Doctor EVER told you that you had any of the following conditions?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Condition** | | | | | | | | | | | | | | | | | **Check One** | | | | | | **Currently Under a Doctor’s Care** | | | | | **Comment** | | |
| Now | | | Past | | |
| Alzheimer’s Disease or Dementia | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Blood Sugar-High | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Blood Pressure (High) | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Cancer | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Deafness or other hearing impairment | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Diabetes | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Endocrine Condition (High or Low thyroid, Pituitary or Adrenal Disease) | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Epilepsy/Seizures | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Heart Attack | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Hyperlipidemia (High blood fat/Cholesterol and/or Trigycerides) | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Joint and connective tissue disease (Lupus, Rheumatoid arthritis, Osteoporosis, Osteoarthritis | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Kidney Disease | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Liver Disease ((Cirrhosis), Hepatitis A/B/C)) | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Mobility Impairment | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Other Cardiac Condition | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Progressive neurological condition (Multiple Sclerosis (MS), Cerebral palsy, Amyotrophic Lateral Sclerosis (ALS)) | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Pulmonary (Emphysema (Chronic Pulmonary Disease (COPD), Asthma) | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Sexually Transmitted or other Communicable Disease (for example, Herpes, Human Immunodeficiency Virus (HIV), History of active tuberculosis) | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Sight Impairment | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Speech Impairment | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Stroke | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Traumatic Brain Injury | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Weight (Obesity, Unexplained Gain or Loss) | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
| Other physical related health conditions | | | | | | | | | | | | | | | | |  | | |  | | | No  Yes | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CURRENT Medication Information**  **None**  (Include all current medication-Psychiatric/Non-Psychiatric, Prescription/Over-the-counter drugs/Herbal) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medication** | | | | **Reason for Taking** | | | | **Dosage/Frequency and When taken** (Dates/Length of time) | | | | | **Side-effects** | | | | | | | | | **Helpful?** | | **Prescriber** | | | | | | |
|  | | | |  | | | |  | | | | |  | | | | | | | | | **No**  **Yes** | |  | | | | | | |
|  | | | |  | | | |  | | | | |  | | | | | | | | | **No**  **Yes** | |  | | | | | | |
|  | | | |  | | | |  | | | | |  | | | | | | | | | **No**  **Yes** | |  | | | | | | |
|  | | | |  | | | |  | | | | |  | | | | | | | | | **No**  **Yes** | |  | | | | | | |
|  | | | |  | | | |  | | | | |  | | | | | | | | | **No**  **Yes** | |  | | | | | | |
| ***Additional***: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medication HISTORY Information**  **None**  **(As best as possible, list all additional medications taken for psychiatric or substance abuse issues in the past)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medication** | | | | **Reason for Taking** | | | | **Dosage/Frequency and When taken** (Dates/Length of time) | | | | | **Side-effects** | | | | | | | | | **Helpful?** | | **Prescriber** | | | | | | |
|  | | | |  | | | |  | | | | |  | | | | | | | | | **No**  **Yes** | |  | | | | | | |
|  | | | |  | | | |  | | | | |  | | | | | | | | | **No**  **Yes** | |  | | | | | | |
|  | | | |  | | | |  | | | | |  | | | | | | | | | **No**  **Yes** | |  | | | | | | |
| ***Additional - Are there any medications you would like to avoid taking in the future?***: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Allergies/Drug Sensitivities**  None  Food (specify):  Medicine (specify):  Latex /  Other (specify): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medical hospitalizations/significant operative and invasive procedures?**  No  Yes If yes, complete information below: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Hospital** | | | | | | **Date** | | | | **Reason** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | |
|  | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | |
| **Comments:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Nutrition/Hydration Screening Check if you have experienced:**   1. **Any weight loss or gain of 10 pounds or more in the past three months** 2. **Change in appetite** 3. **Are you experiencing any other problems eating or drinking?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **The Joint Commission** | | | **Pain Screening**  Do you have any ongoing pain problems?  No  Yes If yes, Medical Staff completes pain section below. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **For Women Only** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Currently pregnant?**  No  Yes - If yes, expected delivery date:  **Are you currently breastfeeding?**  No  Yes | | | | | | | | | | | | | | | | **Receiving pre-natal healthcare?**  No  Yes – If yes, indicate provider:  **Any significant pregnancy history?**  No  Yes – If yes, explain: | | | | | | | | | | | | | | |
| **Menstruation**  **Last menstrual Period Date**:  **Menstrual Pain:**  No  Yes  **Menstrual Irregularities:**  No  Yes  Other: | | | | | | | | | | | | | | | | **Pre-menstrual symptoms:**  No  Yes  **Polycystic Ovary Syndrome?**  No  Yes  If yes, Indicate provider: | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **For Children Only** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Immunizations**: Has the child or adolescent been immunized for the following diseases? Please check all that apply.   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Chicken Pox | Diphtheria | German Measles (rubella) | Hepatitis B | Measles | Mumps | | Polio | Small Pox | Tetanus | Other: | | |   All immunizations up to date? Yes  No – Comments:  Prenatal exposure to Alcohol or other Drugs?  Yes  No – Comments:  **Any other significant information that may affect care or place the child or adolescent at risk (for example, accidents or injuries):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Completed By - Print Name:** | | | | | | | | | **Signature:** | | | | | | | | | | | | | | | | | | **Date:** | | | |
| **Part B. Medical Assessment – (To be completed by Medical Staff/Reviewer)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Vital Signs/Physical Health Indicators** *(Required, Where Indicated, For PROS W/CLINIC & Vitals Required for COA Opioid and Strongly Recommended for Others)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Blood Pressure:** | | | | | **Abdominal girth:** | | | | | | | | | | | | | | **Temperature:** | | | | | **Pulse:** | | | | | | |
| **Respiration:** | | | | | **Height:** | | | | | | | | | | | | | | **Weight:** | | | | | **BMI:** | | | | | | |
| **Nutritional/Hydration Status** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If individual answered yes to any of the items in Nutrition/Hydration Screening above, provide referral information below or rationale if no further action taken:  Does individual have any medical concerns that may interfere with treatment or for which s/he needs assistance?  No  Yes  If Yes, explain: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Pain Assessment** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Individual has pain based on Pain Screen section above:  No  Yes If yes, complete: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Site #1** | | | | | | | | | | | | | | **Site #2** | | | | | | | | | | | | | | | | |
| Location: | | | | | | | | | | | | | | Location: | | | | | | | | | | | | | | | | |
| Description: | | | | | | | | | | | | | | Description: | | | | | | | | | | | | | | | | |
| Pain is adequately controlled:  No  Yes | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| If no, is individual under medical care:  No  Yes - ***If no, make referral and document below:*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Actions Taken** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **OASAS** | | **For those between the ages of 13 and 64:** If HIV Test was negative, has the medical provider  offered an HIV test?  No  Yes If no, explain:    **Did the undersigned check the Prescription Drug Monitoring Program (PDMP) for this individual?**  No  Yes If no, provide reason: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Physical Exam Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **OASAS**  **OASAS** | | No Physical Exam within the past 12 months; within 45 Days the individual will:  Have a physical exam ***[Residential-Attach Copy]***; or  Have a face-to-face assessment by a medical staff member to determine the need for a physical exam  ***[Outpatient-See Referral Section Below]***; or  Be referred for a physical examination ***[Outpatient-Complete Referral Information Below].***  Physical Exam within the past 12 months or admitted directly to the service of another OASAS-certified service; the medical  history and physical examination (including required laboratory tests) from such other services or physicians, (dated:      )  has been reviewed and determined to be current and accurate by:  clinical or medical staff member ***[Residential Signature & Credentials:***       ***Date:***      ***]; or***  medical staff member ***[*Outpatient** ***Signature & Credentials:***       ***Date:***      ***].*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **The Joint Commission** | | **Was Last physical completed more than one year ago?**  No Yes - If Yes, document referral below: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referrals and Recommendations** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **OASAS** | | **Based on Face to Face Medical Assessment:**  **Individual requires physical exam- see referral below, OR** | | | | | | | | | **Individual does not require physical exam** | | | | | | | | | | | | | | | | | | | |
| Nutrition/Hydration Referral:  Pain Referral:  Specialty Care: | | | | | | | | | | | Primary Care Physician (General Referral):  Primary Care Physician for Physical Exam and Date, if known: | | | | | | | | | | | | | | | | | | | |
| Other: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| **Comments, if indicated:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| **Completed By - Print Staff Name/Credentials:** | | | | | | | | | | | | | | | **Staff Signature:** | | | | | | | | | | | | | | **Date:** | |