Medical Forms Packet

Medical information is crucial to implementation of appropriate services for individuals in vocational programs at The Arc.

Enclosed are medical forms which are usually needed for individual vocational files.

Necessary documents usually include:

1. "Physical Examination Form." This DDA approved form is completed by the individual's doctor at the time of the examination. Regulations require this examination be completed on an annual basis, or as needed per the individual's private doctor's recommendations. The doctor may decide in some cases that it is not necessary to perform the Physical Examination every year. In those cases, a short note from the doctor stating such will be acceptable.

2. "Dental Examination Form." This DDA approved form should be completed at each visit to the dentist, usually twice each year. The record file should have at least one of these completed each year.

3. "Physicians Medical Order Form" (P.M.O.F.). This DDA approved form should be completed each time an individual is prescribed medications by the doctor. If the individual receives no medications, the doctor can simply write "none" across the front of it, or indicate "no medications" on the physical examination form.

4. "Vision Exam Form". A vision exam is usually done every two years, or as the doctor/team recommends. The vision specialist should fill this form out at the time of the vision appointment.

5. Audiological exams done by audiologists are usually done on their own forms and submitted to the individual and/or program. No form for such is included in this packet.

Most doctors fill out the forms at the time of the appointments. They then give the completed form to the caregiver/family/individual who returns it to The Arc.

Occasionally a doctor may not give a form back at the time of the appointment for whatever reason. In that event, the caregiver/family/individual should find a way for the doctor to get the form in. If needed, the doctor may fax or mail the form to The Arc. Addresses' and numbers are at the bottom of this page.

Physical Examination Form

(For use on Admission to Program and Annually)

Name: **Date:**

Blood Pressure:	Weight:	Height:
T:_______ P:_______ R:_______		
General Appearance:		Allergies:
Nutritional Status:		

1. Head:		Skin:	
2. Eyes/Vision Screening:	Right Eye:	Left Eye:	
Test Used:			
Conjunctiva:	Sclera:	Left Eye:	
Pupils:	Lens:	Fundi:	
3. Ears/Auditory Acuity:	Right:	Left:	Bilateral:
Test Used:			
Canals:		Drums:	
4. Nose:			
5. Mouth (Gums/Tongue):			
6. Teeth:			
7. Pharynx:			
8. Neck:			
9. Thyroid Gland:			
10. Lymph Nodes:			
11. Chest:			
12. Lungs:			
13. Heart:		Peripheral Pulses:	
14. Breasts:			
15. Abdomen:			
16. Genitalia:		Hernia:	
17. Rectal:			
18. Extremities:			
19. Neurological:			
Orientation:			
State of Consciousness:			
Cranial Nerves:			
DTR:			
Pathological Reflexes:			
Muscle Strength:			
Gait:			
Tone:			
Involuntary Movements:			

20. Joints (Contractures):

Physical Examination Form

21. Spine (Describe any curvature)
22. Tardive Dyskinesia (Perform screening on attached Screening Scale) If client is receiving Behavior Modifying Drugs at the time of examination or has received them in the past year.

Diagnosis: ______________________________

____

____

Lab Result: ______________________________

____

____

Immunizations: ______________________________

____

____

Recommendations: ______________________________

____

____

Diet: ______________________________

____

____

______________________________ ______________

Signature & Title of Individual Performing Exam and completing form. Date

Dental Exam

Name: ____________________________________ Date: __________________

Address: ____

Age: ______________________ Sex: ____________________

Previous Extractions: [ ] Slight Bleeding [ ] Local Anesthesia [ ] General Anesthesia

[ ] Normal Bleeding [ ] Heavy Bleeding

Post-Operative: [ ] Normal Healing [ ] Surgical Dressings

Osteitis: ____

Oral Hygiene Assessment: ____

Treatment Performed at: ____

Oral Examination

Gingiva: Maxilla____________________ Mandible ________________

Growths: ____

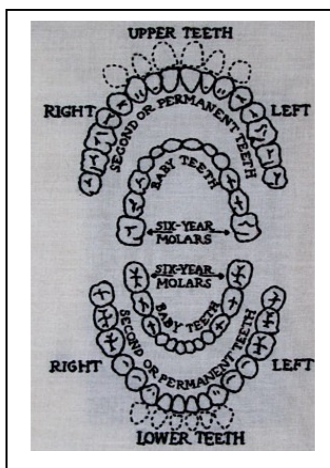
Occlusion: ____

Ulcerations: ____

Other Conditions: ____

Dentures	Type	Satisfactory	Unsatisfactory
Maxilla			
Mandible			

Missing teeth and Existing Restorations, Indicated Work:



Service Rendered: ____________________________________

____

Recommendations: ___________________________________

____

Dentist's Signature: __________________________________

Name Printed: _______________________________________

Address: ____

Phone:

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Name___________________________ MA#_____________________________________

Address_________________________ Med Care#________________________________

________________________________ History___________________________________

Visual Status			**Externals**	
Uncorrected	Corrected	Near	Iris:	Vessels:
O.D.			Sclera:	Lids:
O.S.			Cornea:	
O.U.				

Opthalmoscopy

O.D.	O.S	
Vessels:		Static: O.D. 20/
Disc:		20/
Macula:		O.S. 20/
Fundus:		Subjective: O.D. 20/
Media:		O.S. 20/
		O.U. 20/

Previous Rx												
	Sphere	Cyl	Axis	Add	Prism		Sphere	Cyl	Axis	Add	Prism
Dist.	O.D.					Dist.	O.D.				
	O.S.						O.S.				
Tonometry: O.C.						Near	O.D.	Hgth	Width	Inset	T. Dec.
O.S.						P.D.	O.S.				

Additional Findings:

Referrals:

Fields:

Lens type____________ Color____________

Frame ________________________________

Color ________________________________

Eye Size _____Bridge______ Temple______

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Ophthalmologist______________________________________ Date___________________________

Health Care Professionals Medication/Treatment Order Form

Agency: The Arc of Carroll County, Inc. Address: 180 Kriders Church Road, Westminster, MD 21158

Note: A non-medical person may be administering medication/treatment. If possible, arrange a time for administration so that medication/treatment will not have to be given during work program hours (8:30 a.m.-3:30 p.m.)

Client Name:________________________________ Address:____

Phone: 410-848-4124 Fax: 410-876-5317 Caregiver with Individual:___________________________________ Date:________________________

Please list all Medications/Treatments that have been ordered and/or canceled:

Medication					
Dosage					
Hours Given					
Method to Give Medication/Treatment					
Purpose of Medication/Treatment					
Stop Date					
Possible Common Side Effects					
Conditions which Health Care Professionals should be notified of					

Health Care Professional Signature:

Printed & Signed____ Date____________________________

Copy to Health Services Coordinator
Copy to residence

This Form Must Be Kept Current

Revised 6/1/10

Screening Scale For Tardive Dyskinesia

*To be completed every six (6) months by physician.

Client: ____ MA#____________________________ Rater:__________________

Date: __________________________ Time Observed:____________________ Setting:______________________________

Rating Severity – Use the following guidelines:

1. Absent: Symptom not present at all during period.
2. Fleeting: Symptom present fleetingly during observation period.
3. Mild: Symptom is definitely present, but mild severity occurring occasionally during the rating period (i.e., more than 4 times).
4. Moderate: Symptom is of moderate severity and persists for most of the observation period.
5. Severe: Symptom is very pronounced and is usually present continuously through the observation period.

Face	**Absent**	**Fleeting**	**Mild**	**Moderate**	**Severe**
1. Blinking of eyes	1	2	3	4	5
2. Lip movements (pouting, puckering, smacking)	1	2	3	4	5
3. Chewing movements: bonbon sign	1	2	3	4	5
4. Tongue protrusion, cannot keep tongue out	1	2	3	4	5
5. Tongue Tremor	1	2	3	4	5
6. Grimacing	1	2	3	4	5
Neck and Trunk					
7. Axial Hyperkinesis (abnormal bending and twisting of neck	1	2	3	4	5
8. Torsion movements, rocking	1	2	3	4	5
9. Choreoathetoid movements of fingers & wrist (abnormal spastic movements of finger, wrist, ankles, & toes)	1	2	3	4	5
10. Choreoathetoid movement of ankles & toes	1	2	3	4	5
11. Restless legs (stamping feet, crossing, uncrossing)	1	2	3	4	5
Whole Body					
12. Holokinetic movements (abnormal twisting, bending, turning of the entire body)	1	2	3	4	5

This completed evaluation becomes a permanent part of the client's medical record.