

**Western New York Independent Living**

**Maximizing Independent Living Choices**

**3372 St. Rt. 11, Suite D.**

**Malone, NY 12953**

**P:  (518) 483-2151**

**F:  (518) 483-7491**

**\*\*You must use this form. We encourage you to use your provider and we will assist in paying your copay. If you do not have a provider, we will send you to one of our provider clinics at no cost to you.\*\***

**\*\*TO BE COMPLETED BY THE PERSONAL ASSISTANT \*\***

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE OF BIRTH (DOB):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **TODAY’S DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\* TO BE COMPLETED BY PHYSICIAN or RN\*\***

* **\*This patient is capable of performing duties of a Personal Assistant involving tasks such as bathing, transferring, cleaning, meal preparation, toileting, lifting for another individual. YES\_\_\_ NO \_\_\_**
* **\*This patient is free from any health impairment that is a potential risk to the patient or to other employee or which may interfere with the performance of his/her duties including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs, or substances which may alter the individual’s behavior. YES\_\_\_ NO\_\_\_**
* **ABLE TO LIFT THE FOLLOWING WEIGHT: (Place an X in the appropriate box):**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Less than 10lbs** |  | **10-50lbs** |  | **50-100lbs** |  | **Greater than 100lbs** |

\*\*VACCINATIONS/TESTS (If Applicable)\*\*

|  |  |
| --- | --- |
| **MMR Booster/Vaccination Provided (If Applicable)** | |
| \*Date Given: |  |
| \*Lot #: |  |
| \*Provider Name: |  |
| \*Provider Signature: |  |

**RUBELLA TITER (If Applicable):**

\*Date Given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\***Provider Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MD NP PA RN

**MEASLES TITER (If Applicable):**

\*Date Given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\***Provider Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MD NP PA RN

|  |  |
| --- | --- |
| **MMR Titer (If Applicable)** | |
| \*Date Given: |  |
| \*Results: |  |
| \*Provider Name |  |
| \*Provider Signature |  |

|  |  |
| --- | --- |
| **\*\*PPD Skin Test Administration\*\*** | |
| \*ADMIN Date: |  |
| \*ADMIN TIME: |  |
| \*Manufacturer: |  |
| \*Lot #: |  |
| \*Expiration Date: |  |
| \*Site: Left/Right: |  |
| \*Provider Name: |  |
| \*Provider Signature:  MD NP PA RN |  |
| **\*\*PPD Skin Test Reading\*\*** | |
| \*READ Date: |  |
| \*READ Time |  |
| \*Result: Pos/Neg: |  |
| \*mm induration: |  |
| \*Provider Name: |  |
| \*Provider Signature:  MD NP PA RN |  |

**CHEST X-RAY REQUIRED? Yes No**

**PPD SCREENING:**

**Positive Skin Test + Yes No**

**Negative Chest X-ray** - **Yes No**

**\*Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *PLEASE FAX TO: (518)-483-7491***