

**\*\*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: (585)-815-8502**