AMAZING HOME CARE

Phone Number: 718-863-3300
Fax Number: 718-301-1238

Name :	Social Security # :
Address :	Date of Birth :

PHYSICAL EXAMINATION

Height :	Weight :	Heart :	Lungs :
B.P. :	Pulse :	Back:	Abdomen:
Ears:	Nose:	Throat:	Eyes:

LAB TESTS

1st PPD/Mantoux			mm
	Date Placed	**Date Read**	**Results**
2nd PPD/Mantoux			mm
	Date Placed	**Date Read**	**Results**
OR Quantiferon TB Gold Test			***Attach Lab Report**
	Date	**Results**	
Chest X-Ray			***Attach Lab Report**
	Date	**Results**	
Rubella Titer			***Attach Lab Report**
	Date	**Ratio**	
Rubeola Titer **(If Born in 1957 or later)**			***Attach Lab Report**
	Date	**Ratio**	
Drug Screen **(MUST INCLUDE THC)**			***Attach Lab Report**
	Date	**Results**	

Influenza (Flu) Vaccine				
	Date Administered	**Manufacturer**	**Lot Number**	**Expiration Date**

IMMUNIZATIONS (FOR NON IMMUNE OR EQUIVOCAL)

Rubella		Rubeola		
	Date		**1st Date**	**2nd Date**

☐ The above named individual has a **past history of positive tuberculosis** test and a **negative chest- x-ray,** and is presently demonstrating **NO signs or symptoms of active tuberculosis** and may work without limitations.

Based on health history, physical exams and / or laboratory tests performed, this patient's condition will permit him / her to work in the health care field. In addition, based upon this examination, this individual is free from any health impairment which is of potential risk to the patient or which might interfere with the performance of his / her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or any other drug substances.

*** Please check :** ☐ **Fully Employable** ☐ **Employable with Limitations** ☐ **Not Currently Employable**

PHYSICIAN INFORMATION

Name : _____ **License :** _____ **Date :**_____

Physician Signature : _____ **Facility Stamp :** _____