# Bancroft Rehabilitation Services/BNH
# Admission Physical Examination Report

(This form must be completed no earlier than 48 hours before admission for Lindens and Campus Programs and 90 days for Community)

Date_____

Name_____ Birthdate_____

Parent/Guardian_____

Address_____

_____

**History:**

Allergies:_____
Diagnosis:_____

_____

Medications:_____
Surgeries/Illnesses:_____

_____

_____

Past Medical History: (Seizures, Pica, CHD, HPT, Communicable Diseases, etc.)_____

_____

_____

Present Health Problems:_____

_____

_____

History of Physical Abuse:_____
History of Infectious/Communicable Diseases:_____
Current/Past History Substance Abuse:_____
Onset:_____ Duration:_____
Patterns of Use:_____
Consequences of Use:_____

**Physical Examination**

Height:_____ Weight:_____ Blood Pressure:_____ Pulse:_____

Vision: R_____ L_____ ( Grossly Assessed )

Hearing: R_____ L_____ ( Grossly Assessed )

# Admission Physical Examination Report (Cont'd)

Name_____

Urine Dip: Color: _____
Immunization History Available:_____
Special Diet: (if any)_____
Mantoux: **(Required within 1 year of Admission)**_____

**General Appearance**

(Circle)

Well-Developed Overweight Obese Thin
General Hygiene: Normal Fair Poor
Cooperation: Normal Fair Poor Hostile

Posture:_____
Skin:_____
Head:_____
Head Circumference:_____
Eyes:_____
Pupils:_____
Reaction to light/Accommodation:_____
Ears:_____
Mouth & Throat:_____
Teeth:_____
Nose:_____
Lymph Nodes:_____
Neck:_____
Thyroid:_____
Spine:_____
Thorax:_____
Breasts:_____
Lungs:_____
Heart:_____
Abdomen:_____
Genitalie:_____
Hernia:_____
Rectal Exam:_____
Hemoccult Test:_____
Extremities Musculoskeletal:_____
Neurological Exam:_____
Gait:_____
Coordination:_____

Reflexes:_____

Sensorimotor:_____

## Admission Physical Examination Report (Cont'd)

Name_____

Other Findings:_____

_____

Impressions:_____

_____

**Special Considerations**:

Does this individual have any medical condition that prohibits the use of physical holds/emergency restrains? __yes __no

If yes, please provide concerns/recommendations:

_____

_____

_____

**Suggestions:**

1. Consultations:_____

_____

2. Lab Tests: **(Hep B and Lead Level required for admission)**_____

_____

3. Limitations, if any, to be placed on patient:_____

_____

_____

4. Need for special equipment, facilities, handling, etc.:_____

_____

_____

5. Treatment:_____

_____

_____ _____

Date Physician

**Please attach a list of current medications and dosage**

## Physicians Statement of Non-Exposure To Contagious Or Communicable Disease(s)

**To: Bancroft NeuroHealth/BRS Admissions**

This is to certify that_____ has been examined by the undersigned and that he/she has been found free of any contagious disease(s) and to our knowledge has not been exposed to any communicable diseases during the past 21 days.

**Date** _____

**Signed**_____

(Physician)

**Address**_____

_____

_____

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