ASPIRANET RESOURCE FAMILY PROGRAM

PHYSICIAN'S REPORT

Date of Exam: _____ ☐ Placement ☐ Annual

Patient's Name: _____ DOB: _____ Gender: M F

List All Current Medications:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Allergies: (medication, food, insects) No ☐ Yes ☐ Specify: _____

Height: _____ Weight: _____ BMI: _____ Infant head circumference: _____

Blood Pressure: _____ / _____ Ambulatory ☐ Yes ☐ No

MANDATORY TB RISK ASSESSMENT

TB Risk: ☐ **NO** ☐ **YES** **If YES, PPD Test Completed Date:** _____

If indicated, Chest X-ray Completed Date: _____

	Normal	Abnormal	Not Completed		Normal	Abnormal	Not Completed
Physical Exam	☐	☐	☐	**Health History**	☐	☐	☐
Developmental Assessment	☐	☐	☐	**Evaluation for acute or chronic pain**	☐	☐	☐
Vision Screening	☐	☐	☐	**Blood Lead Test**	☐	☐	☐
Audiometric screening	☐	☐	☐	**Blood (Anemia) Test**	☐	☐	☐
Dental Assessment	☐	☐	☐	**Urine Test**	☐	☐	☐
Nutrition Evaluation	☐	☐	☐	**Other:** _____	☐	☐	☐

DIAGNOSIS/RECOMMENDATIONS/REFERRALS:

_____ _____

Physician's Name (Please print) *Physician's Phone*

_____ _____ _____ _____

Physician's Address: Street *City* *State* *Zip Code*

_____ _____

Physician's Signature *Date*