

BCT PHYSICAL ASSESSMENT TO BE COMPLETED BY HOSPITAL STAFF (MD AND/OR RN)

Assessment Performed by: _____

 [Print Name and Title] [MD or RN]
 _____ / _____ / _____ @ _____
 Signature D M Y Time

Attach Patient Label

Evidence of:

- IV drug track marks No Yes
- Jaundice No Yes
- Genital Lesions No Yes
- Oral Thrush No Yes
- Large Scabs or Necrotic Lesions No Yes
- Anal tears/perianal warts No Yes
- Trauma to chest or abdomen No Yes
- Palpable Masses No Yes
- Rash No Yes

If suspected or unsure, please confirm with MD:

- Blue/purple spots (eg. Kaposi sarcoma) No Yes
- Obvious Corneal Scarring No Yes
- Enlarged Lymph Nodes No Yes

Isolation Precautions:

- No Yes
- Type: _____

Allergies:

- No Yes
- Type: _____
- Reaction: _____

Pulmonary:

- Tube Size: _____
- Endotracheal Trach (Cuffed or Uncuffed)
- Air Entry:
 - Even
 - Uneven describe: _____
- Breath Sounds:
 - Clear
 - Other describe: _____
- Chest Tubes:
 - None Right Left
 - Drainage: _____

Cardiovascular:

- Heart sounds:
 - Normal
 - Abnormal describe: _____
- Peripheral Pulses:
 - Present
 - Absent location: _____
- Color:
 - Pink Pale Dusky Jaundice
 - Other: _____

Gastrointestinal:

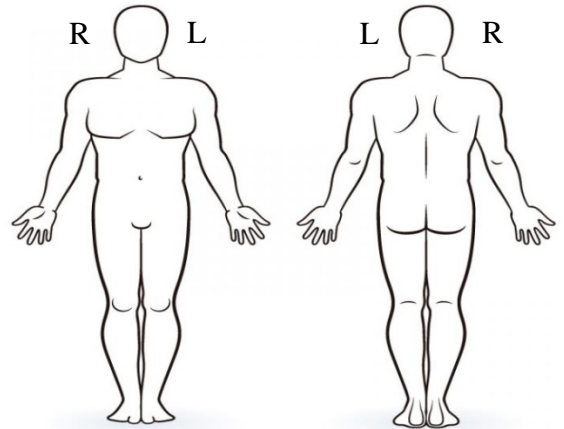
- Abdomen:
 - Soft
 - Distended
- Bowel Sounds:
 - Present
 - Absent
- GI/GU tubes:**
 - NG/OG
 - Gastrostomy
 - Foley Catheter
 - Surgical Drains
- Location: _____

Implanted Devices:

- (e.g. IVC filter, pacemaker)
- No Yes
- Type: _____
- Please indicate any of the following directly on the diagram with the corresponding number:**

 1. Tattoos
 2. Piercings
 3. Incisions
 4. Bruises
 5. Lacerations
 6. Palpable Masses
 7. Large scabs/Lesions
 8. Dressing/Splints/Casts
 9. Old Surgical Sites
 10. IV drug track marks
 11. Other: _____

- None of above present



Actual Height: _____ cm/inches

Dry Weight: _____ kg

Comments:

