**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:  

<table>
<thead>
<tr>
<th>Evidence</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV drug track marks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jaundice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genital Lesions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Thrush</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large Scabs or Necrotic Lesions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anal tears/perianal warts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma to chest or abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palpable Masses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rash</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If suspected or unsure, please confirm with MD:  

<table>
<thead>
<tr>
<th>Evidence</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue/purple spots (e.g. Kaposi sarcoma)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obvious Corneal Scarring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enlarged Lymph Nodes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Isolation Precautions:  

<table>
<thead>
<tr>
<th>Isolation Precautions</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

Allergies:  

<table>
<thead>
<tr>
<th>Allergies</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

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: ________________

Implant Devices:  

(e.g. IVC filter, pacemaker)  

<table>
<thead>
<tr>
<th>Implant Devices</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

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

Invasive Lines (location):  

- CVC: ________________  
- Art line: ________________  
- PIV: ________________  
- Other: ________________

Actual Height: ________ cm/inches

Dry Weight: ________ kg

Comments: ________________

[Diagram]

**ODHD-ODS.04.007 Rev 04 Eff Date: 22-April-2019**

**BCT Donor Log#:**