PLEASE FAX TO 604-877-2136

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

*Assessment Performed by:*_____ *[MD❑ or RN❑]*

[Print Name and Check Title]

_____ ____/____/_____@_____

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:_____

Invasive Lines (location):

- ❑ CVC:_____
- ❑ Art line:_____
- ❑ PIV:_____
- ❑ Other:_____

Implanted Devices:

(e.g. IVC filter, pacemaker)

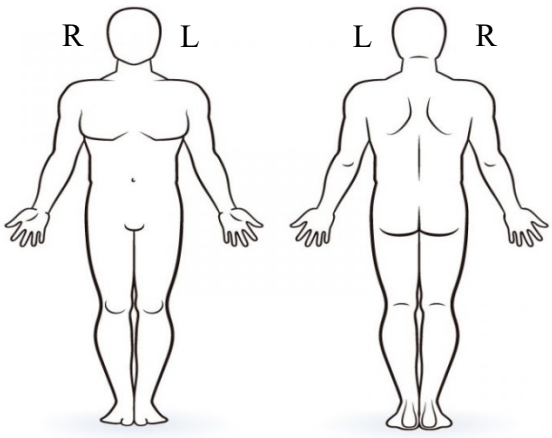
❑ No ❑ Yes

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:_____