BCT PHYSICAL ASSESSMENT TO BE COMPLETED BY HOSPITAL STAFF (MD or RN)

Assessment Performed by: ____________________________

[Print Name and Title] [MD or RN]

___________________________________    ______/______/_____/____________
Signature  D  M  Y  Time

Evidence of:
Non-medical injection of drugs  □ No  □ Yes  Anal tears/perianal warts  □ No  □ Yes
Jaundice  □ No  □ Yes  Trauma to retrieval sites  □ No  □ Yes
Genital Lesions  □ No  □ Yes  Blue/purple spots (Kaposi sarcoma)  □ No  □ Yes
White spots in mouth  □ No  □ Yes  Enlarged lymph nodes  □ No  □ Yes
Large Scabs/Rash/Lesions  □ No  □ Yes  Palpable Masses  □ No  □ Yes

PULMONARY:
Airway:                          Tube Size:__________________
                      □ Endotracheal  □ Trach
Chest tube:                         □ Left Chest  □ Right Chest  □ None
Breath Sounds:                      □ even  □ uneven  □ absent L/R  □ clear  □ other (describe): ____________________________

CARDIOVASCULAR:
Lines (location):                   □ PA catheter _____________  □ CVP _____________  □ Art line _____________
Peripheral Periph Pulses:           □ normal  □ irregular  □ Heart Tones: □ normal □ other (describe) ______________
Periph Edema:                       □ present  1  2  3  4 □ absent  Periph Edema: □ present  1  2  3  4 □ absent
Thoracic Evaluation:                □ normal  □ chest trauma (describe) ______________ □ Other____________________

INTEGUMENTARY:
Color:                              □ pink  □ dusky  □ pale  □ other____________________
Temperature:                       Temp: ___________ Warming/cooling devices used __________________________

GASTROINTESTINAL:
Tubes:                              □ NG/OG  □ gastrostomy  □ surgical drains  □ None
Abdomen:                           □ soft  □ firm  □ distended  □ non-distended
Bowel Sounds:                      □ present  □ absent

GENITOURINARY:
Foley Catheter:                     □ No  □ Yes  type ___________  size ___________
Urine Volume:                      □ anuric  □ <100 cc/hr □ 100-500 cc/hr □ >500 cc/hr
Appearance:                        □ clear  □ cloudy  □ hematuria  □ other____________________

MUSCULOSKELETAL:
Fractures:                         □ closed  □ compound/open  □ dressings/splints  □ traction  □ calf-compressor device  □ None

PLEASE INDICATE ANY OF THE FOLLOWING FINDINGS DIRECTLY ON DIAGRAM:

1. Tattoos
2. Piercings
3. Incisions
4. Surgical Scars
5. Bruises
6. Lacerations
7. Track Marks
8. Palpable Masses
9. Large Scabs/Rash/Lesions
10. Other (Describe): ____________________________

Comments: __________________________________________________________

Describe any consultation on findings: __________________________________________

Consultation with (Name): ________________________________________________

Recommendations: ________________________________________________________

Height: _________  Weight: _________

Abdominal Girth: □ N/D