

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

Attach Patient Label

Evidence of:

- IV drug track marks No Yes
- Jaundice/Hepatomegaly No Yes
- Genital Lesions No Yes
- Oral Thrush No Yes
- Large Scabs or Necrotic Lesions No Yes
- Rash No Yes

- Anal tears/perianal warts No Yes
- Trauma to chest or abdomen No Yes
- Blue/purple spots (Kaposi sarcoma) No Yes
- Enlarged lymph nodes No Yes
- Palpable Masses No Yes
- Corneal Scarring No Yes

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):

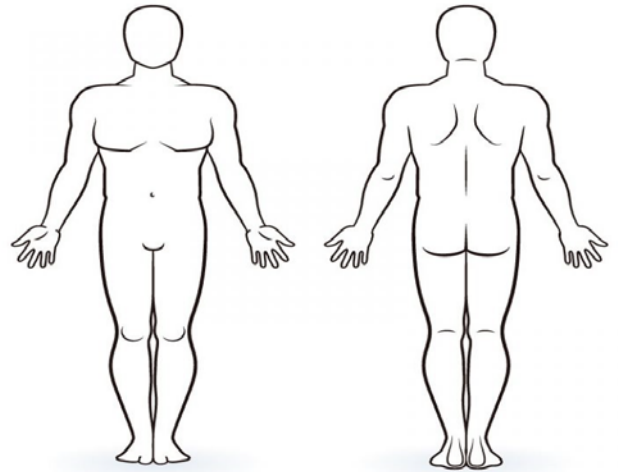
- CVC: _____
- Art line: _____
- PIV: _____
- Other: _____

Implanted Devices:

- (e.g. IVC filter, pacemaker)
- Yes
- Type: _____
- No

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: _____



Actual Height: _____ cm/inches

Dry Weight: _____ kg

Comments:

