Riverside- San Bernardino County

**Physical exam request form**

Riverside-San Bernard County Indian Health

Indian Health, INC.

115551/2 Potrero Road, Banning Ca. 92220• (951) 849-4761

HH PARTICIPANT PHYSICAL EXAM

This patient has volunteered to participate in the RSBCIHI Diabetes Program – **Healthy Heart Project,** which is part of the IHS – National Healthy Heart Project. The patient is required to complete an annual physical exam (PE) to participate in the project to determine eligibility and clearance for physical activity.

Purpose Of The PE: Using your clinical judgment, identify any medical problems that may exclude this patient from the project or impact the patient’s ability to fully participate in intensive physical activities, e.g., ability to exercise, determine need for cardiac clearance, indicate need for special dietary considerations, and address potentially serious conditions or stabilize current medical conditions. If you have any questions about this PE form, please call the patient’s Healthy Heart Case Manager at (951) 769-7853 ext. 113, or the Project Coordinator at ext 115.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PART A: Physical Exam (To be completed by Provider) | | | | | | | | | | |
| **Inclusions** **For Participation:** | | | | | | | | | | |
| **Diagnosis of diabetes** | 🖵 Yes | | | 🖵 No | |  |  |  | | |
| **If yes, what type of diabetes** | 🖵 Type 1 | | | 🖵 Type 2 | | 🖵 Other | | | | |
| **Exclusions** **For Participation:** | | | | | | | | | | |
| **Current diagnosis of pregnancy** | | 🖵 Yes | 🖵 No | | **End Stage Renal Disease on dialysis** | | | | 🖵 Yes | 🖵 No |
| **Active alcohol or substance abuse** that would affect successful participation | | 🖵 Yes | 🖵 No | | **Current diagnosis of cancer** Undergoing treatment that prohibits participation | | | | 🖵  Yes | 🖵 No |
| **Current diagnosis of cardiovascular disease** | | 🖵 Yes | 🖵 No | | **If yes, what type of CVD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **If yes, is patient’s CVD unstable?**  Provider judgment  **stop** | | | | 🖵 Yes | 🖵 No |
| **Note: They may be included if they have CVD, but only if it is stable!** | | | | | | | | | | |

**This is a supplement to the standard H & P form. Both must be completed.**

PATIENT NAME DATE:

DOB

CHART#

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| --- | --- | --- | --- | --- | --- |
| **PART B: Clearance for Physical Activity (To be completed by Provider)** | | | | | |
| **Any conditions that limit physical activity**   * **None**  **By checking this box, the patient is medically cleared for physical activity.** * **Yes**   **If Yes, what are the limitations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |
| **PART C: Dietary Restrictions (To be completed by Provider)** | | | | | |
| **Any conditions that require dietary restrictions (e.g. low salt, no grapefruit)**   * **None**  **By checking this box, the patient has no dietary restrictions.** * **Yes**   **If Yes, what are the restrictions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |
| PART D: Labs & EKG (To be completed by Provider and Nursing Staff) | | | | | |
| Labs needed to be ordered for this screening(Only order labs that have *not* been completed within past 90 days) | | | | | |
| 🖵 A1C | | 🖵 Lipid Panel (fasting) | | | 🖵 Serum Creatinine/GFR |
| 🖵 Fasting blood sugar | | 🖵 UA/Microalbumin/AC ratio | | | 🖵 Liver Function |
| 🖵 Other \_\_\_\_\_\_\_\_\_\_\_\_\_ | | Evidence of Microalbuminuria?  🖵 yes 🖵 no | | | Evidence of Proteinuria?  🖵 yes 🖵 no |
| EKG complete (within last 90 days) | 🖵 yes 🖵 no | | Referral to cardiologist? 🖵 yes 🖵 no | | |
| PART E: Physical Screening Confirmation | | | | | |
| This patient has discussed with me his/her interest in the Healthy Heart Project. This patient is receiving medical care for diabetes treatment including cardiovascular disease risk reduction. The history and physical exam form has been placed in the medical record. Any exclusions listed on this form have been noted. Any conditions limiting physical activity, if any, have been noted. Additional procedures performed or instructions are also noted (e.g. dietary restrictions, referrals to cardiologist, etc). | | | | | |
| Medical provider (signature) | | | | Date | |

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