OMB Number: 2900-0759
Expiration Date: Xxx, 20XX
Respondent Burden: 7 minutes

VA | U.S. Department of Veterans Affairs

GENERAL MEDICAL/PHYSICAL EXAM FORM

NATIONAL VETERANS SUMMER SPORTS CLINIC

(To be completed by Examining Clinician)

PRIVACY ACT: VA is asking you to provide the information on this form under USC, Chapter 5, Section 521 and Chapter 17, Section 1710. VA may disclose the information that you put on this form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 121VA19 "National Patient Databases - VA". Providing the requested information is voluntary. However, you will not be able to participate in the event without furnishing this information.

RESPONDENT BURDEN: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this application will average 7 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the forms.

Dear Clinician: Please fill out completely the two medical pages. In addition, please include (1) a copy of a recent EKG for anyone 40 years of age and older, (2) a recent H&P/Problem list and (3) a list of current medications and dosages. **PLEASE TYPE OR PRINT CLEARLY**

PATIENT'S NAME	SOCIAL SECURITY NUMBER *(Last 4 digits only)*	DATE	AGE

PATIENT'S DAYTIME PHONE NUMBER *(Include area code)*	CELL PHONE NUMBER *(Include area code)*	VAMC WHERE PATIENT RECEIVES CARE

PRIMARY DISABILITY/DIAGNOSIS

DATE OF ONSET _____

☐ SPINAL CORD INJURY (SCI) - LEVEL _____ ☐ COMPLETE ☐ INCOMPLETE

☐ PARAPLEGIC ☐ QUADRIPLEGIC

☐ MULTIPLE SCLEROSIS (MS)

☐ TBI/POLYTRAUMA ☐ LOW ☐ MODERATE ☐ HIGH

☐ CVA WITH RESIDUAL _____

☐ AMPUTEE ☐ RIGHT LEG, A/K, B/K ☐ RIGHT ARM, A/E, B/E

☐ LEFT LEG, A/K, B/K ☐ LEFT ARM, A/E, B/E

☐ PTSD ☐ LOW ☐ MODERATE ☐ HIGH

☐ BURNS

☐ VISUAL IMPAIRMENT

VISUAL IMPAIRMENT DIAGNOSIS ***(For Visually Impaired patient's ONLY)***

IS THE PATIENT LEGALLY BLIND?

☐ YES ☐ NO ☐ VISUAL ACUITY (<20/200 OU) ☐ VISUAL FIELD LOSS (<20 DEGREES OU) ☐ TOTALLY BLIND

DESCRIPTION OF REMAINING VISION?

_____

PLEASE RATE YOUR PATIENTS LEVEL OF INDEPENDENCE

☐ INDEPENDENT WITH SELF CARE NEEDS, INDEPENDENT ONCE ORIENTED

☐ INDEPENDENT WITH SELF CARE NEEDS, NEED SIGHTED GUIDE OCCASIONALLY AFTER ORIENTATION

☐ INDEPENDENT WITH SELF CARE NEEDS, NEED SIGHTED GUIDE CONTINUOUSLY

☐ NEED SOME ASSISTANCE WITH SELF CARE, NEED SIGHTED GUIDE

PATIENT NEEDS

PATIENT REQUIRES ATTENDANT? ☐ YES ☐ NO IF YES, ATTENDANT NAME _____

USES WHEELCHAIR MAJORITY OF TIME? ☐ YES ☐ NO

WILL THIS PATIENT NEED TO PARTICIPATE SITTING DOWN? ☐ YES ☐ NO

USES OTHER ADAPTIVE EQUIPMENT? ☐ YES ☐ NO IF YES, WHAT _____

SITTING BALANCE

☐ NORMAL ☐ FAIR ☐ POOR

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PATIENT'S NAME	SOCIAL SECURITY NUMBER *(Last 4 digits only)*

MEDICAL HISTORY - DO NOT SEND IN WITHOUT ALL OF THE FOLLOWING

1. Attach your recent H & P (history and physical) problem list with all medical and surgical history.
2. Attach recent **(within last 6 months)** EKG for any patient **40 years of age and older.**
3. Attach list of active medications.
4. Attach discharge summary for any patient hospitalized during the last three (3) years.

ALLERGIES

DOES THE PATIENT HAVE DYSREFLEXIA? ☐ YES ☐ NO IF YES, EXPLAIN _____

DOES THE PATIENT HAVE ANTICOAGULATION OR OXYGEN REQUIREMENTS? ☐ YES ☐ NO IF YES, EXPLAIN _____

DOES THE PATIENT SMOKE? ☐ YES ☐ NO

ALCOHOL OR SUBSTANCE ABUSE? ☐ YES ☐ NO IF YES, DESCRIBE _____
(We require documentation of at least 6 months sobriety from drugs and/or alcohol in order to participate.)

CARDIOPULMONARY REVIEW OF SYSTEMS WAS DONE AND IS UNREMARKABLE ☐ YES

PHYSICAL EXAM *(To be filled out completely by physician)*

HEIGHT _____ *(inches)* WEIGHT _____ *(pounds)*

Weight limit for anyone who is dependent is 250 pounds; weight limit for those who can participate independently is 300 pounds.

PULSE _____ BLOOD PRESSURE _____

HEENT _____ CARDIAC _____

PULMONARY _____ ABDOMEN _____

EXTREMITIES _____ NEURO _____

Dear Clinician: Your patient is planning on participating in a **vigorous** outdoor summer sporting rehabilitation clinic. Examples of high-risk patients are: **a smoker who is overweight; brittle diabetics; patients with significant COPD or CHF**; and patients that require **close medical supervision**. High risk patients: those with potential sun exposure risks and possible hypothermia risks - these events will be outside in high sun and potential cold water temperatures. Patients are admitted to this clinic based on your judgements about their current health status.

IF THEY REQUIRE HOSPITALIZATION FOR A PRE-EXISTING CONDITION, YOUR MEDICAL CENTER WILL BE LIABLE FOR ANY CHARGES INCURRED OUTSIDE OF VA CARE. DO NOT SEND ANY PATIENT THAT IS CURRENTLY UNSTABLE OR UNDERGOING EVALUATION FOR CLINICAL INSTABILITY.

If the patient's condition changes before the event, please contact Michal "Kalli" Hose, MD at the VA San Diego Healthcare System, or contact the Division of General Internal Medicine through e-mail MichalKalli.Hose@va.gov.

☐ PATIENT **IS** MEDICALLY/BEHAVIORALLY FIT TO PARTICIPATE ☐ PATIENT **IS NOT** MEDICALLY/BEHAVIORALLY FIT TO PARTICIPATE

SIGNATURE AND TITLE OF EXAMING CLINICIAN	NAME OF EXAMING CLINICIAN *(Please print)*
HOSPITAL AND ADDRESS OF EXAMINING CLINICIAN	TELEPHONE NUMBER *(Recent)*
	EXAMINING CLINICIAN'S E-MAIL ADDRESS