FAMILY CHOICE HOME HEALTHCARE

HEALTH FORMS

Applicant Name

Family Choice Healthcare

Physical Form

_____ _____

Applicant/Employee Name **Date**

Family Choice Healthcare employs Registered Nurses, as supervisors, and Home Care Attendants, who assist clients with Activities of Daily Living (ADL's) - i.e. toileting, bathing, assisting with transferring and performing household chores. Employees are in close contact with clients who have various illnesses and disabilities in a home environment. Employees work from a plan of care approved by the client's Health Care Provider that may include lifting and/or turning during the course of providing client care.

The statement below must be completed by an examining Physician/Nurse Practitioner to certify that the applicant/employee is physically and mentally capable of performing supervisory and/or personal care duties.

I have examined _____(employee name) on _____ (date) and have determined that he/she_____ (is) _____(is not) capable of performing personal care duties.

Comments:

_____ _____

Physician Name/Title (PRINT) **Date**

_____

Physician Office Number

Please return to:

Family Choice Healthcare

4601 Forbes Boulevard, #320, Lanham, Maryland 20706

888.358.1341 ext.103 ~ Fax: 301.200.4723

FAMILY CHOICE
HOME HEALTHCARE

MEMORANDUM

To: Clinical Staff

Re: Hepatitis B Vaccine Series

As advised by the State of Maryland Department of Health and Mental Hygiene, Family Choice Healthcare strongly recommends that all employees receive Hepatitis B vaccine series. The Hepatitis B vaccine series gives our employees added protection when working with clients who may have been exposed to the Hepatitis B disease.

This inoculation series is *voluntary* and is not required by Family Choice. If during your next physical you decide to start the vaccine series, please have your physician *complete* and *sign* the appropriate areas on the back of the *PPD/Hepatitis B Form* (enclosed). The *PPD/Hepatitis B Form* should be returned to Family Choice by fax or mail to:

Family Choice Healthcare

4601 Forbes Boulevard, #320, Lanham, Maryland 20706

(Fax) 301.200.4723

If you have received the Hepatitis B Vaccine in the past, please provide the applicable documentation and sign below.

If you opt *NOT* to have the Hepatitis B vaccine series, please indicate this below. It is important to note that if you decline the series, you must sign below and return this form to our office.

☐ **I have elected to receive the Hepatitis B Vaccine.**

☐ **I have received the Hepatitis B Vaccine in the past and will provide the agency documentation.**

☐ **I have not received the Hepatitis B Vaccine and choose not to receive it at this time.**

If you have any questions, please call 888.358.1341 extension 102.

_____ _____ _____

Name (Print) **Signature** **Date**

PPD/HEPATITIS B FORM

Family Choice Health Care requires annual TB testing, unless otherwise indicated by a licensed Physician/Nurse Practitioner. It is also highly recommended that all clinical employees receive the Hepatitis B vaccine.

This form must be completed by your Health Provider and returned to Family Choice Healthcare *before* placement and as a condition of continued employment.

If you have any questions, please call 888.358.1341 ext.103.

_____ _____

Applicant/Employee Name **Date**

TO BE COMPLETED BY EXAMINING HEALTH PROVIDER ONLY

Name of Provider_____

Office Address_____

Telephone No._____

TUBERCULIN TESTING

TEST #1: MANTOUX_____ INJECTOR_____ Lot #_____

Exp. Date_____

DATE TESTED: _____ **TESTED BY:**_____

RESULTS (In mm) _____ READ BY:_____DATE READ:_____

TEST #2: MANTOUX_____ INJECTOR_____ Lot #_____

Exp. Date_____

DATE TESTED: _____ TESTED BY:_____

RESULTS (In mm) **_____** READ BY:_____DATE READ:_____

Which tests were done to verify the individual is free from active TB?

- ❑ T-SPOT **DATE:_____ RESULT_____**
- ❑ CHEST X-RAY: **DATE**_____ **RESULT**_____

HEPATITIS B

#1_____ #2_____ #3_____

(Date) (Date) (Date)

- ❑ **Declined by Employee:** _____

(Employee Signature)

PROVIDER NAME _____ PROVIDER SIGNATURE _____

DATE _____