VINLAND NATIONAL CENTER

Full lives for people with disabilities

Vinland Medical Screening Form

Version January 8, 2019

CLIENT NAME / Date of Birth _____

1. When did you last see a doctor or health care provider? _____
2. Facility Questions:
    a. Do you require 24 hour skilled nursing care? _____
    b. Are you free of communicable disease? _____
    c. Self preservation skills: in an emergency (fire, gas leak), are you able to take proper action (get out of the building)? _____
    d. Diet: regular / pureed / diabetic / mechanical _____
3. What medications & doses are you currently taking? _____
    _____
    a. Do you take any controlled substances/narcotics, who manages this? _____
    _____
    b. Are you on Clozaril, who manages this? _____ _____
    c. Do you have an ACT team? _____
4. What medications & doses are you SUPPOSED to be taking?_____
    _____
5. What are your allergies to medications, foods, etc? _____
6. What are your current medical diagnoses?_____
    _____
7. What chronic medical conditions do you have? _____
8. What pharmacy do you fill your prescriptions at?_____
9. Who is your Primary Care Provider (provider name & clinic name)?_____
    _____
    a. Could they fax a copy of your current medication list to us? _____
10. Do you have any infections which could spread to others? _____
    a. Any history of MRSA? _____
        i. Any active lesions or sores or bites? _____
    b. Past History or current symptoms of TB?
    _____
    c. Who manages your diabetes? _____
11. Have you had a blood clot (Deep vein thrombosis - DVT, pulmonary embolism - PE)? _____
    a. Are you currently on a blood thinner? _____
    b. If taking Coumadin/warfarin, who manages this? _____
12. Do you feel that your current medical problems warrant ongoing care while at Vinland? _____

Please fax to: 763.479.4372