VINLAND NATIONAL CENTER | Full lives for people with disabilities

Vinland Medical Screening Form

Version March 17, 2020

CLIENT NAME / Date of Birth: _____
Date this form filled out: _____

Person helping client fill out this form & contact #: _____

1. When/Where did you last see a doctor or health care provider? _____
2. Insurance Questions:
   a. Do you have VA Health Care? If yes, please provide policy name/number: _____
   b. Do you have secondary prescription insurance plan? Policy name/number: _____
   c. If on Medicare, please list *all* policy numbers: _____
3. 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 _____
4. 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? _____
5. What medications & doses are you SUPPOSED to be taking? _____
   _____
6. What are your allergies to medications, foods, etc? _____
7. What are your current medical diagnoses? _____
8. What chronic medical conditions do you have? _____
9. What are your mental health diagnoses? _____
10. Who is your Primary Care Provider (provider name & clinic name)? _____
    a. Could they fax a copy of your current medication list to us? _____
11. 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? _____
       i. When & where was your last TB test done? What were the results? _____

ii. Night sweats, cough, bloody sputum, fevers, unintended weight loss_____

12. Any history of seizures?_____
13. Have you, or any of your close contacts*, traveled outside of the country/state within the past couple months? (*A close contact is defined by someone you live with or are in close contact with every day)_____
14. Do you have symptoms of a cough or fever?_____
15. Are you diabetic?_____
    a. Insulin?_____
    b. Oral medications?_____
    c. Who helps you manage your diabetes?_____
16. 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?_____
17. Do you feel that your current medical problems warrant ongoing care while at Vinland?_____

Please fax to: 763.479.4372