



Full lives for people with disabilities

## Vinland Medical Screening Form

January 2024 Version

CLIENT NAME / Date of Birth: \_\_\_\_\_

Date this form is filled out: \_\_\_\_\_ Gender Identity: Male/Female/Non-Binary/Other: \_\_\_\_\_

Last date of use: \_\_\_\_\_ Substances used: \_\_\_\_\_

**HOW DO WE BEST CONTACT YOU?** Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Person helping client fill out this form and Contact#: \_\_\_\_\_

Facility Questions:

- a. Do you require 24-hour skilled nursing care? \_\_\_\_\_
- b. Self-preservation skills: In an emergency (fire, gas leak), are you able to take proper action (get out of the building)? \_\_\_\_\_
1. What medications and doses are you currently taking? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  - a. Do you take any controlled substances/narcotics? \_\_\_\_\_  
Who manages this? \_\_\_\_\_
  - b. What medications and doses are you SUPPOSED to be taking? \_\_\_\_\_  
\_\_\_\_\_
2. Do you have any allergies to medications, foods, etc? \_\_\_\_\_
3. What are your current medical diagnoses? \_\_\_\_\_
4. What chronic medical conditions do you have? \_\_\_\_\_
5. What are your mental health diagnoses? \_\_\_\_\_
6. Do you have any infections which could spread to others? \_\_\_\_\_
  - a. Any history of MRSA? \_\_\_\_\_
    - i. Any active lesions, sores or bites? \_\_\_\_\_
  - b. Past history or current symptoms of TB? \_\_\_\_\_
    - i. When and where was your last TB test done? What were the results?  
\_\_\_\_\_
    - ii. Night sweats, cough, bloody sputum, fevers, unintended weight loss?  
\_\_\_\_\_
7. Any history of seizures? \_\_\_\_\_
8. 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)  
\_\_\_\_\_
9. Do you have symptoms of a cough or fever? \_\_\_\_\_
10. Are you diabetic? \_\_\_\_\_
  - a. Insulin? \_\_\_\_\_
  - b. Oral medications? \_\_\_\_\_
  - c. Who helps you manage your diabetes? \_\_\_\_\_
11. Have you had a blood clot (DVT-Deep Vein Thrombosis, PE-Pulmonary Embolism)?  
\_\_\_\_\_
  - a. Are you currently on a blood thinner? \_\_\_\_\_
  - b. If taking Coumadin/Warfarin, who manages this? \_\_\_\_\_

**Please fax to Intake: 763.225.4656 or call 763.479.3555 to complete this over the phone with an intake counselor. You can also email this to: [Intake@vinlandcenter.org](mailto:Intake@vinlandcenter.org)**