GENESIS RECOVERY SERVICES, INC.
2825 W. 42nd Avenue
Anchorage, AK 99517
Phone: (907) 243-5130 Fax: (907) 248-8350

(REQUIRED WITH-IN 48 HOURS PRIOR TO ADMISSION TO TREATMENT)

PHYSICAL EXAMINATION FORM

Name: ____ Date of Birth: _________________
Address: ____
Home Phone: ____________________________ Cell Phone:___________________________

Blood Pressure: _________ Pulse: _______ Respirations:_______ Temp:_____________
Height: ________________ Weight: ___________

PPD Skin Test Date/Location placed:_______________ initials:______
(Read with-in the last 30 days) Date Read: _________________________ initials:______
Results: __________mm

Please check appropriate box.

	NORMAL	ABNORMAL
Eyes		
Ears		
Nose/Throat		
Mouth		
Dentition		
Lymph node		
Heart		
Lungs		
Abdomen / GI		
Genitals *or* **Deferred		
Orthopedic		
Nervous System		
Skin		
Endocrine		
Nutrition		
Speech		
Musculoskeletal		

If abnormal findings, Is treatment necessary?________________________
Is treatment being received? ___________________
Has treatment been completed?__________________

Medications (Please list): 1.____
2.____________________________________ 3. ____
4. ____________________________________ 5. ____
State limitations, if any:____
Is patient stable enough to enter treatment? ( ) YES ( ) NO Comments:_________________
____
____

___________________________________ ____________________________ ____________
(Physician's Signature) (Print Physician's Name) (Date)

GENESIS RECOVERY SERVICES, INC.

Client Name: ______________________________________ Date: ___________________

In order for this client to receive/take over the counter (OTC) medication(s), Regulatory entities require a physician's order/approval to ensure the medication is NOT contraindicated. The medications that we stock for client's PRN use follows. Please initial each medication approved/allowed. If medication is not initialed, it will not be dispensed to client. Please complete, sign and date this form.

MEDICATION NAME	**PHYSICIAN INITIAL**
IBUPROFEN**	
ASPIRIN**	
TYLENOL**	
TYLENOL P.M. **	
NIGHTTIME COLD MEDICINE**	
DAYTIME COLD MEDICINE**	
TUMS**	
ANTI-DIARRHEAL**	
ALEVE**	
ADVIL**	
PEPCID**	
DULCOLAX**	

***** (ALL OTC MEDICATIONS ARE STRICTLY GIVEN ONLY PER LABEL DIRECTION)***

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Physician Signature

____ _________________________

Physician Printed Name Date