CERTIFICATION BY PHYSICIAN FOR LONG-TERM CARE SERVICES AND PHYSICAL EXAMINATION FOR PASARR LEVEL II

State Form 45278 (2-92) / Form 450B/PASARR2A - Section VI

This form is **CONFIDENTIAL** according to IC 12-1-7 *et esq.*, IC 4-28-6.1,IC 16-4-1.6-8, 470 IAC 1-3-1.

INSTRUCTIONS: *This form must be completed for long-term care services for individuals with mental retardation; developmental disability or related condition.*

Name of applicant / resident	Name of facility / city

VITALS				
Weight	Height	Pulse	Blood pressure	Temperature

HEAD	EYES (*Include Fundi*)			EARS		
	(*Complete if individual is visually impaired.*)			(*Complete if the individual is hearing impaired.*)		
	DISTANT VISION	R	L	HEARING (*Air Conduction*)		
	Uncorrected	/20	/20	CPS 500 1000 1500 2000 4000 6000		Weber Test R
	Corrected	/20	/20	R	L	Renne Test L

PHYSICAL EXAM	N	AB	Describe abnormalities checked on physical:
1. Nose			
2. Throat			
3. Mouth / Teeth			
4. Speech / Language			
5. Neck			
6. Lymphatic system			
7. Chest			
8. Breasts			
9. Lungs			
10. Cardio Vascular			
11. Abdomen			
12. Genitalia			
13. Orthopedic			
14. Neurological			
15. Skin			
FEMALE			
16. Pelvic			
17. Rectal			
18. Bimanual exam			
MALE			
19. Rectal			
20. Prostate			

DISPOSITION AND RECOMMENDATION

Referral or special examinations required?

☐ No ☐ Yes (*if "Yes", specify*)

Medical rehabilitation potential: ☐ Good ☐ Fair ☐ Poor	Type of facility recommended:	
Signature of physician	**Typed/Printed name of physician**	**Date**