TPC RN CHECKLIST

Individual:_____ **Date:**_____

Diagnosis:_____

Medications: _____

Allergies: _____

Insurance: **Medicaid ☐** _____
Medicare ☐ _____
Blue Cross/Blue Shield ☐_____
Other ☐_____

Immunizations:	
TB:	MMR:
Tetanus:	DPT:
Hepatitis Screening: #1_____ #2_____ #3_____	Other: PPD: #1 _____ #2 _____.
Flu:	Oral Polio:
Pneumovax	Hib:

Physical:	Blood Pressure:
Diet/Feeding Problems:	Weight:
Hearing Eval:	AIM Scale:
Pap Smear:	Menses:
Mammogram:	
Nursing Assessment:	
Ability to Self- Medicate:	Medical Summary:
LAB WORK: • Cholesterol:_____ • CBC:_____ • UA:_____ PSA Drug Levels:	Other:
Status of Seizure Disorder: *(if applicable)*	Adaptive Equipment:

Individual:_____ **Date:**_____

Specialist Visits:	**Last Seen**	**Return to Office**
Psychiatric:		
Neurology:		
Cardiology:		
Dermatology:		
Podiatry:		
Gynecology:		
Ophthalmology:		
Endocrinology:		
Nephrology:		
Gastroenterology:		
E.N.T.:		
Oncology:		
Nutritional:		
Audiology:		
P.T.		
O.T.		
Speech:		
Dentist:		