The Physicians Centre Hospital

In Partnership with Physician Owners

Infections Control Surveillance Tool for Communicable Disease

1. Are your vaccinations up to date (including flu and pneumonia if applicable)?
   Yes_____ No_____If outpatient and not current w/vaccines, please refer to PCP.
2. Have you been in contact with someone who has a contagious disease?
   Yes_____No_____
   If yes, please describe:
   _____

3. Have you traveled outside of the US in the last 30 days?
   Yes_____No_____ If yes, please describe:
   _____

Fall Assessment

1. Have you fallen in the past 3 months? Yes_____No_____
2. Do you use assistive devices at home (walker, cane, eyeglasses) that you did not bring with you? Yes_____No_____
3. Do you experience dizziness or weakness? Yes_____No_____

Imaging Screening: ***RADIOLOGY PATIENTS ONLY (excluding mammo)***

1. History of illness or injury? Why did your doctor order this test?_____
2. What area is affected? (example: inside part of right knee, upper left abdomen pain, upper right sided chest pain)_____
3. How long has this been going on?_____

_____
Patient Signature

_____ _____
Printed Name Witness

_____
Date