Mid-Ohio Psychological Services, Inc.
Physical Health Assessment Review Feedback

Location: □ Columbus □ Delaware □ Lancaster □ Newark □ Ross

Client Name: _____ ID: _____
Clinician: _____ Review Date: _____

Please do the following:

□ **Have client SIGN the Physical Health Assessment.**

□ **Have client COMPLETE the Physical Health Assessment.**

□ **Verify immunizations.**

□ **Instruct client to contact their physician for the following reason (and note in case note):**

□ **Other:**

Please note the following:

□ **Mental health condition may be affected by the following medical condition:**

□ **Mental health condition may be affected by the following medication:**

□ **Other**

□ **Return to agency nurse.**

□ **Return to file room.**

_____

Staff Registered Nurse

Rev. 4/9/2012