CLINICAL EXAMINATION BY FIELD PHYSICIAN

OTHER DISEASES, WORK CAPACITY, FUNCTIONAL PERFORMANCE, NEED OF CARE - RECAPITULATION

LOCALITY

ID NUMBER | DATE | HOUR

PHYSICIAN

I OTHER DISEASES

A. Clinical history:

B. Symptoms:

C. Status:

D. Diagnostic evaluation:

| | Diagnosis | | | | Need of care/control | | Adequacy of care/control | | | | Need of new measures | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | possible | definite | previous | new | no | yes | no care/control | inadequate | proposed, not accompl. | adequate | general practitioner | specialist | control of finding(s) only |
| 1. Diabetes | 1 | 2 | 1 | 2 | 0 | 1 | 0 | 1 | 2 | 3 | 1 | 2 | 3 |
| 2. Hyperlipidaemia | 1 | 2 | 1 | 2 | 0 | 1 | 0 | 1 | 2 | 3 | 1 | 2 | 3 |
| 3. Anaemia | 1 | 2 | 1 | 2 | 0 | 1 | 0 | 1 | 2 | 3 | 1 | 2 | 3 |
| 4. Bacteriuria | 1 | 2 | 1 | 2 | 0 | 1 | 0 | 1 | 2 | 3 | 1 | 2 | 3 |
| 5. Renal failure | 1 | 2 | 1 | 2 | 0 | 1 | 0 | 1 | 2 | 3 | 1 | 2 | 3 |
| 6. _____ ⌊⌊⌊ | 1 | 2 | 1 | 2 | 0 | 1 | 0 | 1 | 2 | 3 | 1 | 2 | 3 |
| 7. _____ ⌊⌊⌊ | 1 | 2 | 1 | 2 | 0 | 1 | 0 | 1 | 2 | 3 | 1 | 2 | 3 |
| 8. _____ ⌊⌊⌊ | 1 | 2 | 1 | 2 | 0 | 1 | 0 | 1 | 2 | 3 | 1 | 2 | 3 |
| 9. _____ ⌊⌊⌊ | 1 | 2 | 1 | 2 | 0 | 1 | 0 | 1 | 2 | 3 | 1 | 2 | 3 |
| 10. _____ ⌊⌊⌊ | 1 | 2 | 1 | 2 | 0 | 1 | 0 | 1 | 2 | 3 | 1 | 2 | 3 |
| no significant diagnoses | | | | | | | | | | | | | 0 |

## II ASSESSMENT OF FUNCTIONAL CAPACITY

| A. ABILITY TO MOVE | | FUNCTION OF UPPER LIMBS |
|---|---|---|
| 0 | no limitation | 0 |
| 1 | slight limitation | 1 |
| 2 | marked limitation | 2 |
| 3 | complete or almost complete limitation | 3 |

| B. PHYSICAL PERFORMANCE (assessment of maximal working capacity) | |
|---|---|
| HEAVY PHYSICAL ACTIVITY<br>- light turning or lifting or carrying continuously<br>- heavy turning or lifting or carrying even occasionally | 0 |
| MODERATE PHYSICAL ACTIVITY<br>- light turning or lifting or carrying fairly frequently<br>- much walking without additional work load | 1 |
| LIGHT PHYSICAL ACTIVITY<br>- fairly heavy manual work in a sitting position<br>- standing without additional work load<br>- fairly much walking without additional work load | 2 |
| LIGHT SEDENTARY ACTIVITY | 3 |
| CANNOT PERFORM ANY OF THE ACTIVITIES MENTIONED ABOVE | 4 |

C. WORKING CAPACITY

(present or latest job)

| | |
|---|---|
| UNLIMITED WORKING CAPACITY | 0 |
| SLIGHTLY LIMITED WORKING CAPACITY<br>- occasional difficulty in ordinary tasks<br>or<br>- regular difficulty in heavy or demanding tasks | 1 |
| MARKEDLY LIMITED WORKING CAPACITY<br>- regular difficulty in ordinary tasks<br>or<br>- cannot accomplish heavy or demanding tasks<br>or<br>- long periods on sick leave | 2 |
| INCAPABLE TO WORK | 3 |
| RETIRED DUE TO AGE OR HAS NEVER HAD ANY JOB | 8 |

D. GENERAL FUNCTIONAL CAPACITY

| | |
|---|---|
| UNLIMITED FUNCTIONAL CAPACITY | 0 |
| SLIGHTLY LIMITED FUNCTIONAL CAPACITY<br>- occasional difficulty in light daily activities<br>or<br>- regular difficulty in heavy daily activities | 1 |
| MARKEDLY LIMITED FUNCTIONAL CAPACITY<br>- regular difficulty in light daily activities<br>or<br>- cannot perform some heavy activity at all | 2 |
| ALMOST COMPLETELY OR COMPLETELY LIMITED FUNCTIONAL CAPACITY<br>- cannot perform some light activity at all | 3 |
| NOT CLASSIFIABLE<br>- because of: _____<br>_____ | 8 |

## III SUMMARY ASSESSMENT OF DISEASES CAUSING FUNCTIONAL LIMITATIONS

NO SUCH DISEASE [0]

A. CARDIOVASCULAR DISEASES [1]

diagnoses: 1)_____ |_|_|_|

2)_____ |_|_|_|

3)_____ |_|_|_|

B. RESPIRATORY DISEASES [1]

diagnoses: 1)_____ |_|_|_|

2)_____ |_|_|_|

3)_____ |_|_|_|

C. MUSCULOSKELETAL DISEASES [1]

diagnoses: 1)_____ |_|_|_|

2)_____ |_|_|_|

3)_____ |_|_|_|

D. OTHER SOMATIC DISEASES [1]

diagnoses: 1)_____ |_|_|_|

2)_____ |_|_|_|

3)_____ |_|_|_|

E. MENTAL DISORDERS [1]

diagnoses: 1)_____ |_|_|_|

2)_____ |_|_|_|

3)_____ |_|_|_|

## IV ASSESSMENT OF NEED OF LONG-TERM (≥ 3 months) TREATMENT / CARE OR CONTROL

NO NEED OF LONG-TERM CARE OR CONTROL [0]

| | | | | ADEQUACY OF CURRENT CARE/CONTROL 1) | |
|---|---|---|---|---|---|
| | | | | inadequate | adequate |
| A. LONG-TERM NEEDS OF: | no | infrequently (≤1-2/yr) | frequently (≥3/yr) | | |
| 1. CONSULTATIONS | [0] | [1] | [2] | | |
| by [1] general practitioner | | | | [0] | [1] |
| [1] specialist | | | | [0] | [1] |
| specialities: _____ | | | ⌊⌋⌊⌋ | | |
| _____ | | | ⌊⌋⌊⌋ | | |
| [1] other (psychologist, public health nurse ...) | | | | [0] | [1] |
| specify: _____ | | | ⌊⌋⌊⌋ | | |
| _____ | | | ⌊⌋⌊⌋ | | |
| | no | yes | | | |
| 2. MEDICATION | [0] | [1] | | [0] | [1] |
| | no | yes | | | |
| 3. OTHER THERAPY AND CARE | [0] | [1] | | | |
| what? [1] nursing measures | | | ⌊⌋⌊⌋ | [0] | [1] |
| what? (injections, changes of catheter ...) _____ | | | | | |
| _____ | | | | | |
| [1] aids, prothesis | | | ⌊⌋⌊⌋ | [0] | [1] |
| what/why? _____ | | | | | |
| _____ | | | | | |
| [1] other therapy (physiotherapy ...) | | | ⌊⌋⌊⌋ | | |
| what/why? _____ | | | | | |
| _____ | | | | | |
| | no | infrequently (≤1-2/week) | frequently (≥3/week) | | |
| 4. NON-MEDICAL CARE | [0] | [1] | [2] | [0] | [1] |

| B. ADMINISTRATION AND LEVEL OF CONTROL OR CARE | | | | | |
|---|---|---|---|---|---|
| | primary care | primary and special care 2) | special care | | |
| 1. LEVEL MAINLY | [1] | [2] | [3] | | |
| | ambulatory care | hospital | other institution | | |
| 2. ADMINISTRATION MAINLY AT | [1] | [2] | [3] | [0] | [1] |

1) To be filled only when the subject needs the measures mentioned. If several measures are needed, consider the most inadequate one.

2) Primary care mainly, with regular consultations at special care level

## V ASSESSMENT OF NEED OF SHORT-TERM TREATMENT / CARE OR CONTROL

NO NEED OF SHORT-TERM CARE OR CONTROL [0]

| | ADEQUACY OF CURRENT CARE/CONTROL [1] | |
|---|---|---|
| | inadequate | adequate |

A. SHORT-TERM NEEDS OF
(in addition to long-term needs):

| | no | yes | | |
|---|---|---|---|---|
| 1. CONSULTATIONS | [0] | [1] | | |
| by [1] general practitioner | | | [0] | [1] |
| [1] specialist | | | [0] | [1] |
| specialities: _____ | | | ⌊⌋⌊⌋ | |
| _____ | | | ⌊⌋⌊⌋ | |

| | no | yes | | |
|---|---|---|---|---|
| 2. MEDICATION | [0] | [1] | [0] | [1] |

| | no | yes | | |
|---|---|---|---|---|
| 3. OTHER THERAPY AND CARE | [0] | [1] | | |
| what? [1] physiotherapy | | | [0] | [1] |
| what/why? _____ | | | ⌊⌋⌊⌋ | |
| _____ | | | | |
| [1] surgery | | | [0] | [1] |
| what/why? _____ | | | ⌊⌋⌊⌋ | |
| _____ | | | | |
| [1] other measures (nursing, advice ...) | | | [0] | [1] |
| what/why? _____ | | | ⌊⌋⌊⌋ | |
| _____ | | | | |
| _____ | | | | |

B. ADMINISTRATION AND LEVEL OF CONTROL OR CARE

| | | | | | |
|---|---|---|---|---|---|
| 1. LEVEL MAINLY | primary care [1] | primary and special care[2] [2] | special care [3] | | |
| 2. ADMINISTRATION MAINLY | ambulatory care [1] | hospital [2] | | [0] | [1] |

1) To be filled only when the subject needs the measures mentioned. If several measures are needed, consider the most inadequate one.

2) Primary care mainly, with regular consultations at special care level

VI REFERRAL TO CARE/CONTROL

| | |
|---|---|
| no findings indicating further measures | 0 |
| significant finding(s), already referred to care/control, no need of further measures | 0 |

A. REFERRED BY THE FIELD PHYSICIAN:

| | | |
|---|---|---|
| finding: | to subsequent control at ambulatory care | 1 |
| diagnoses: | to tuberculosis dispensary | 2 |
| | to physician | 2 |
| | to hospital | 3 |
| incomplete information concerning: | service still in progress | 1 |
| | service completed | 2 |

B. REFERRAL BY LETTER AFTER THE FIELD PHASE:

| | | |
|---|---|---|
| diagnoses: | to subsequent consultation by a doctor | 1 |
| | to immediate consultation by a doctor | 2 |
| | to hospital | 3 |
| | to tuberculosis dispensary | 2 |
| date __/__ -____ | service completed | 1 |
| _____ signature | | |