COBB COUNTY COMMUNITY SERVICES BOARD
DOUGLAS COUNTY COMMUNITY SERVICES BOARD

Policy # 8068	Physical Health Assessment
Origination Date: March 1998	
Revision Date: July 2005; March 21, 2006; July 26, 2007; February 24, 2009, July 14, 2016 Reviewed Date: January 2004; June 29, 2007; May 28, 2010, June 9, 2013	
Approved: Bryan G. Stephens Interim Executive Director	Jamie L. Allison, MA, LPC Jamie Allison, Chief Quality Officer

POLICY:

It is the policy of the Cobb County Community Services Board and the Douglas County Community Services Board to consider each client's physical health as an essential component of comprehensive assessment, treatment planning and treatment.

PROCEDURE:

1. In Outpatient Services, clinical staff screens physical health needs for all clients during the Admission Assessment and appropriate referrals made as needed to a private practitioner, public health department, private clinic or other health care organization.
2. For clients admitted to the Behavioral Health Crisis Unit (BHCC), a physical examination is performed by a credentialed licensed independent practitioner, a physician's assistant, or APRN under the supervision of a qualified physician within 24 hours. For clients admitted to all other residential and therapeutic foster care programs a physical examination is performed by an agency or community physician within 10 days of admission. For clients remaining longer than one (1) year in residential programs, all substance abuse programs, and all developmental disability programs, the physical examination will be updated at least annually.
3. For clients who are children, adolescents or developmentally disabled in residential, the physical assessment includes: motor development and functioning; sensorimotor functioning; speech, hearing, and language function; visual functioning; immunization status; and oral health and hygiene. This assessment screens for less-than-optimal functioning and may result in referral for immediate intervention or more in depth evaluation as indicated. Significant findings or referrals are noted in the Plan of Care. Staff will request results of the referral and incorporate into the client's chart.
   Follow-up of referrals are documented in the Clinical Record.
4. If a comprehensive medical history and physical examination by a licensed independent practitioner has been completed within 30 days before admission to the agency, a copy of it may be used as the physical assessment if a review and update by the program physician is documented with any additions, the date and physician's initials.