# FIREFIGHTER Annual Physical Program

**Introduction**

Welcome to Vantage Physicians and the Firefighter Annual Physical Program!

We are excited to work with you to provide a comprehensive physical health exam and risk assessment. The Firefighter Annual Physical at Vantage Physicians is unique program for the members of the Fire Department to complete their required annual physical. The following handbook sets out the features and benefits of this program.

The Firefighter Annual Physical Program includes a complete physical exam tailored to the demands and risks inherent of employment in this field, and is compliant with the NFPA 1582 Standard on Comprehensive Occupational Medical Program for Fire Departments. It includes, but is not limited to, the following:

* Comprehensive History including a Risk Assessment Questionnaire
* Complete Physical
* Hearing and Vision Testing
* Body Composition Analysis
* Grip Strength Evaluation (dynamometer)
* Electrocardiogram
* Spirometry
* Hemoccult
* Lab Tests (Blood and Urine Testing)
* Chest X-ray (baseline and as indicated)
* Cancer Screening
* Immunizations and Infectious Disease Screening
* In-depth review and written report of the findings and diagnostic data obtained during the exam mailed directly to you as soon as the results of your labs are collected (approximately 2 weeks).

Your exam will be scheduled by the fire department. Prior to arriving for your exam, please review the all the materials in your packet. It will outline the process of the exam as well as include all the requested forms that should be completed prior to your exam.

As Vantage Physicians is a patient-centered practice, we will always be open to your suggestions regarding other services we may offer. Please never hesitate to contact us should you have any questions or concerns about the Firefighter Annual Physical or any other component of the Vantage Physicians program. One of the advantages to our practice is we are available by phone or email to answer your health-related questions throughout the year, not just on the day you are scheduled.

## Frequently Asked Questions

* **Will I get a written report of all my diagnostic testing? Yes.** Following your physical, your physician will document all the diagnostic testing and exam findings as well as their interpretation, impression and recommendations. This report will be mailed directly to you within 14 days of your exam (if you were fasting on the date of your exam and your lab work was drawn). If you do not receive this report within this time, please contact us as soon as possible.
* **Are my records secured? Are they confidential? Yes** and **yes**. Our practice utilizes an Electronic Medical Record (EMR) called Practice Partner, by McKesson. Our ECG and Spirometry equipment directly input data into this system. We maintain a redundant data back-up protocol, with an off-site server. This allows us to quickly recover lost information in the event of a network breakdown. Lastly, our EMR allows for easy transfer of records in both digital and printed format for the entire chart or for specifically designated information.
* **Do I pay or have a co-pay? No.**  Your Annual Physical, including all labs and diagnostic testing are paid directly by the Fire Department. Should you receive any bills in error please contact us immediately.
* **Is this different and separate from membership at Vantage Physicians? Yes.** The Firefighter Annual Physical is a “once-a-year” comprehensive exam which includes all the services described in this handbook. A membership at Vantage Physicians is a separate program that provides a higher level of access to your personal primary care physician on your schedule. In addition, it includes all the services your primary care physician would otherwise provide, including working with you to define, implement and follow-up on any problems that may have been identified during your physical. The goal of the program is to remove many of the barriers between patients and physicians that have become standard in today’s over-worked medical offices.
* **How can I learn more about the Vantage Physicians’ membership?** Simply contact us at your convenience or ask for a New Patient Information packet at the time of your annual Fire Fighter Physical.

# Policies and Customs

The following outlines more specific policies and customs of the Firefighter Annual Physical Program at Vantage Physicians. These are separate to the policies and customs described in the Vantage Physicians Patient Handbook. Please note that our focus is not on these minute details but rather on our service and relationship with you. These are guided by our legal counsel to inform and to protect both you and your physician from any potential misunderstandings.

# The Firefighter Annual Physical Program Handbook expressly mentions those services provided by your Vantage Physician that are covered by your participation.

# Non-Covered Services. Any items not specifically mentioned here should be consider non-covered. Examples of services not covered with participation specific include those described in the Vantage Physicians Membership. Other examples include: specialist visits; diagnostic tests not provided by your Vantage Physician; laboratory tests; hospital or emergency room facility fees; surgical fees; outside facility fees such as nursing home or hospital fees; litigation costs and fees; medical record fees; or costs of some immunizations or medication given as an injection.

**Office Hours** are Monday through Friday 8:30 am to 5:00 pm. Office closure dates for holidays are posted on our website. Office closures may occur due to severely inclement weather or natural disaster. Unless otherwise directed, Fire Fighter Physicals will be scheduled by fire department administrative staff.

**Participation in the Annual Physical at Vantage Physicians is voluntary**. Vantage Physicians does not discriminate based on general health, age, sex, race or creed and there is no consideration of healthcare insurance status. In order to qualify for the Firefighter Annual Physical Program, a member must be in good standing within the Fire Department and qualify under its wellness physical program. Each member must indicate their understanding and agreement with the policies and customs of Vantage Physicians and this special program as outlined within the Agreement Contract.

**Thank you.**

# FIREFIGHTER Physical Program

**Intake Form**

|  |
| --- |
| Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Vantage Physician (circle one): Dr. Kershisnik / Dr. Edwards |

|  |
| --- |
| Patients Name: |
| Previous Names or Aliases: |
| Nickname (if applicable): |
| Home Address: |
| Mailing Address (if different from home): |
| Email Address: |
| Home Number: ( ) |
| Work Number: ( ) |
| Cell Number: ( ) |
| Sex (please circle one): Female Male |
| Date of Birth: |
|  |

|  |
| --- |
| **Emergency Contact Information:** |
| Name: |
| Relationship to the Patient: |
| Home Phone Number: |
| Work Phone Number: |
| Cell Number: |
| Address: |

# FIREFIGHTER Annual Physical Agreement

This agreement is between Drs. Edwards and Kershisnik ("Physician"), whose principal place of business is at Vantage Physicians, 3703 Ensign Road Suite 10A, Olympia, WA 98506 and patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ("Patient"), who resides at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

The Patient agrees, understands and expressly acknowledges the following:

Initial:

\_\_\_\_\_\_ I have received and reviewed the Firefighter Annual Physical Handout, which outlines the services of this unique program within Vantage Physicians and expresses its covered and non-covered services as well as the general policies and customs of this program. Further, I have had the opportunity to ask questions and receive answers regarding its content.

\_\_\_\_\_\_ I acknowledge and understand that the relationship between myself and the Physician is solely limited to the Annual Physical described here and in the Handbook. The Physician is not assuming management of my health nor assuming the role as my acting primary care physician.

\_\_\_\_\_\_ I acknowledge and understand that any membership policies described and expressed in the Vantage Physicians Patient Handbook do not apply to this unique program and agreement. I am solely participating under the Firefighter Annual Physical Program.

\_\_\_\_\_\_ I acknowledge and understand that any fees related to this unique program will be billed directly to the Fire Department.

\_\_\_\_\_\_ I acknowledge and understand that all services provided by Vantage Physicians and their staff will be within the community standards of medicine.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient - Print Date VP Staff – Print Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient - Signature Date VP Staff – Signature Date

Hearing Screening Form

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Yes No** Do you suffer from any of the following?

\_\_\_ \_\_\_ Known hearing loss?

\_\_\_ \_\_\_ Dizziness?

\_\_\_ \_\_\_ Tinnitus or Ringing in the ears?

\_\_\_ \_\_\_ Ear pain?

\_\_\_ \_\_\_ Do you work in a high noise area? Where and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ Do you wear hearing protection? What kind?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ Have you ever worked in an area of high noise exposure?

 If so what type of job and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Did you use hearing protection? Always | Occasionally | Rarely | Never

 What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ Are you having trouble with your hearing today?

\_\_\_ \_\_\_ Do you have cold/allergies that maybe affecting your hearing today?

Have you had a hearing test before? If so when and where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ Have you ever been seen by a physician for your ears or been referred

to an ear specialist or audiologist?

The above is true and correct to the best of my knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature Date

|  |  |
| --- | --- |
| **RIGHT** | **LEFT** |
| 500 | 1000 | 2000 | 3000 | 4000 | 6000 | 8000 | 500 | 1000 | 2000 | 3000  | 4000 | 6000  | 8000 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Audiometer: Welch Allyn 232 Serial Number: AR067893**

**VP Testing Staff:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Tested:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Test Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Vision Screening Form

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Yes No**

\_\_\_ \_\_\_ Do you work around or with materials that may affect your vision or be

considered hazardous to your eyes?

\_\_\_ \_\_\_ Do you wear protective eye gear? What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ Have you ever had an injury or toxic exposure to your eyes?

 If so when and where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ Do you wear glasses or contacts? Please circle.

\_\_\_ \_\_\_ Are you having any eye or vision trouble at this time?

\_\_\_ \_\_\_ Do you have difficulty distinguishing colors or been told you have color blindness?

\_\_\_ \_\_\_ Have you ever seen an eye physician or optometrist?

When was your last eye exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above is true and correct to the best of my knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature Date

**RIGHT EYE** Uncorrected 20 / \_\_\_\_\_ Corrected 20 / \_\_\_\_\_

 **LEFT EYE** Uncorrected 20 / \_\_\_\_\_ Corrected 20 / \_\_\_\_\_

 **BOTH EYES** Uncorrected 20 / \_\_\_\_\_ Corrected 20 / \_\_\_\_\_

 **ISHIHARA TEST** Not Done \_\_\_\_\_WNL\_\_\_\_\_ Color Blind \_\_\_\_\_

**VP Testing Staff:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Tested:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Test Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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