UNIVERSITY OF IOWA HEALTH CARE- HTC PHYSICAL

PHYSICAL EXAM: <u>To be completed by your Hemophilia Treatment Center (HTC)</u>.

PLEASE send or have your HTC fax a copy of your most recent Treatment Plan and last clinic note signed by your HTC or Hematologist

Child's Name_____ Date of Examination_____
Weight _____kg Height: _____cm Blood Pressure _____/_____

Major sites of hemorrhage during the past year (target joints, muscle, soft tissue) _____
_____

Physical Examination:

	Normal	Abnormal		Normal	Abnormal
Head and Neck	_____	_____	Skin	_____	_____
Eyes and Ears	_____	_____	Lymphatic	_____	_____
Nose and Throat	_____	_____	Neurological	_____	_____
Chest	_____	_____	Orthopedic	_____	_____
Heart	_____	_____	Psychological	_____	_____
Abdomen	_____	_____			

Explain Abnormalities: _____
_____

Assessment:_____
_____
_____

Recommendations/Concerns:_____
_____

<u>HTC Information-</u>
Name of HTC: _____
HTC Contact: _____
Phone Number:_____
Fax Number: _____

_____
Physician's signature

_____
Physician's name printed

Please fax this form to Michelle/Karla at 319-356-4261 by June 6th.