



Intellectual and/or Developmental Disabilities (IDD)
Physical Exam Form

Please return this completed form to:
Washington County Community Services - IDD Intake Unit
14949 62nd St. N., P.O. Box 30, Stillwater, MN 55082
Phone: 651-430-6422 | Fax: 651-430-6527 | Email: CSAAD-IDD-Eligibility@washingtoncountymn.gov
(A copy of a physical form from your medical provider can be provided in lieu of completing this form.)

Name: _____ Date of Exam: _____
Age: _____ DOB: _____ Height: _____ Weight: _____ BMI: _____
Blood Pressure: _____ Pulse: _____ Temp: _____ Resp.: _____

Diagnoses

Please list all diagnoses:

Allergies

Please list all allergies (with reaction, if applicable):

Is the patient free of communicable disease? Yes No

If no, name of disease and precautions necessary: _____

Has this client been tested for Hepatitis B? Yes No

Date: _____ Results: Positive Negative

Physical Exam

Please provide a summary of your patient's physical exam and any treatment plans:

Provider's Name (please print): _____

Provider's Signature: _____

Clinic Name: _____ Clinic Phone #: _____

Clinic Address: _____