Spartanburg Regional Healthcare System

Corporate Health

# Firefighter Health and Medical Services

To prepare for your Health Assessment and Physical, we ask that you:

- Bring your completed medical history forms.
- Do not eat or drink for 8 hours prior to having your blood drawn. You may take your medicine, drink water, or black decaf coffee.
- Avoid tobacco in any form and caffeine for at least 3 hours.
- Wear clothing to permit freedom of movement, preferably shorts (and underwear), and walking or running shoes. You will be expected to perform sit-ups, push-ups, and ride a bicycle.
- Be prepared to give a urine sample.
- Bring your glasses.
- Avoid loud noises for 14 hours before the test. (You may need to wear earplugs to cut grass, etc.)
- Please arrive promptly at your scheduled time.
- Please call 864-560-9663 to cancel or reschedule your appointment.

**Your physical is scheduled for:**_____

**Partial**

Corporate Health - Spartanburg
2660 Reidville Road, Unit
Spartanburg, SC 29301
P: 864-560-9696
F: 864-560-9636

Corporate Health – Pelham
150 D Street,
Greer, SC 29651
P: 864-879-1948
F: 864-801-4398

Spartanburg Regional Healthcare System

Corporate Health

# PHYSICIAN'S MEDICAL RECOMMENDATION REPORT FOR FIRE CHIEF OR EMPLOYER

ASSOCIATE NAME: _____ DATE: _____

SOCIAL SECURITY NUMBER: _____ JOB TITLE: _____

EMPLOYER / FIRE DEPARTMENT: _____ PHONE NUMBER:_____

***Based on current state, local and all applicable OSHA standards, work suitability determination for performing firefighter duties to include structural firefighting is as follows:***

_____ RECOMMENDED, NO LIMITATIONS

_____ RECOMMENDED WITH LIMITS

_____ NOT RECOMMENDED FOR INTERIOR FIRE FIGHTING

_____ MEDICAL CLEARANCE FOR USE OF RESPIRATOR

_____ NOT CLEARED FOR RESPIRATOR USE MEDICALLY

_____ HOLD FOR FURTHER EVALUATION

Comments: _____
_____
_____

Next Steps: _____ Retest
_____ Medical Records
_____ Referral to specialist

PHYSICIAN'S SIGNATURE: _____ Date: _____

☐ 2660 Reidville Road, Unit 1
Spartanburg, SC 29301
Phone: 864-560-9651

☐ 150 D Street
Greer, SC 29651
Phone: 864-849-9180

Spartanburg Regional Healthcare System

Corporate Health

**PHYSICIAN'S MEDICAL RECOMMENDATION REPORT FOR FIREFIGHTER**

ASSOCIATE NAME: _____ DATE: _____

SOCIAL SECURITY NUMBER: _____ JOB TITLE: _____

EMPLOYER / FIRE DEPARTMENT: _____ PHONE NUMBER:_____

Physical Type: _____ (Full or Partial)

***Based on current state, local and all applicable OSHA standards, as well as, NFPA 1582 guidelines, work suitability determination for performing firefighter duties to include structural firefighting is as follows:***

_____ RECOMMENDED, NO LIMITATIONS

_____ RECOMMENDED WITH LIMITS

_____ NOT RECOMMENDED FOR INTERIOR FIRE FIGHTING

_____ MEDICAL CLEARANCE FOR USE OF RESPIRATOR

_____ NOT CLEARED FOR RESPIRATOR USE MEDICALLY

_____ HOLD FOR FURTHER EVALUATION

_____ OVERWEIGHT: OBESITY INDEX IS: _____kg/m² (Ideal index is <25).
*Suggest losing weight.*

_____ OBESE: OBESITY INDEX IS: _____kg/m²
*Stongly suggest medically supervised weight loss program.*

_____SUGGEST FOLLOW UP FOR: _____
*Follow up with your personal physician is recommended for the above listed condition.*

| | | | | | |
|---|---|---|---|---|---|
| _____ | PFT | ☐ | Normal | ☐ | Abnormal |
| _____ | Hearing test | ☐ | Normal | ☐ | Abnormal |
| _____ | Lab work | ☐ | Normal | ☐ | Abnormal |
| _____ | EKG | ☐ | Normal | ☐ | Abnormal |
| _____ | Fitness level | ☐ | Pass | ☐ | Fail |

Comments: _____
_____
_____

Spartanburg Regional Healthcare System

Corporate Health

# Corporate Health Medical History Questionnaire


**O** 2660 Reidville Road, Unit 1
Spartanburg, SC 29301
Phone: 864-560-9651
Fax: 864-560-9636

**O** 150 D Street
Greer, SC 29651
Phone: 864-849-9180
Fax: 864-801-4398


**Today's Date**:_____

**Patient Name**:_____ **Company Name:**_____

**SSN**:_____ **Sex:** _____ **Birth Date:**_____

## Section A - Have You Ever…

| | Yes/No | If Yes, please explain… |
|---|---|---|
| had an operation | | |
| received advice to have an operation | | |
| been a patient in a psychiatric unit | | |
| had a serious injury | | |
| been refused employment for health reasons | | |
| had a positive drug test result | | |
| had or do you have an opiate or substance abuse addiction | | |
| given up a job because of health reasons | | |
| had to be hospitalized | | |
| had a worker's compensation injury | | |
| had a worker's compensation impairment rating | | |
| received a VA disability rating | | |
| received any long-term financial disability benefits | | |
| been rejected or discharged from military service for health reasons | | |
| been refused life insurance | | |
| become ill because of your work | | |
| had a driver's license revoked or denied for health reasons | | |
| had or now have an illness which could affect your work | | |

## Section B - Regarding Your Health

| | Yes/No | | Yes/No |
|---|---|---|---|
| Have you ever injured your back | | Have you ever had a head injury | |
| Have you ever worn a back brace | | Do you need glasses to read | |
| Have you ever worn a knee brace | | Do you need glasses for distance | |
| Do you ever wear a truss | | Do you wear contact lenses | |
| Have you had (or do you have) a hernia or rupture | | Do you ever use a hearing aid | |
| Have you ever had an illness treated with x-ray (cancer, etc) | | Do you take medicine regularly (please list in Section E) | |
| Have you ever worked with radioactive material | | Have you used "street" drugs (cocaine, speed, crack, heroin, marijuana, etc.) | |
| Have you ever worked in a dusty trade | | Do you drink alcoholic beverages | |

Medical Group of the Carolinas
A Division of Spartanburg Regional Healthcare System

MGC Corporate Health
Site Name or Number

# GENERAL CONSENT TO TREAT/
# PATIENT AUTHORIZATION/ACKNOWLEDGEMENT OF BENEFITS RELEASE

The following are the conditions for services provided by the Medical Group of the Carolinas which is affiliated with Spartanburg Regional Health Services District, Inc. (District) for the patient whose name appears at the bottom of this page.

**CONSENT FOR MEDICAL TREATMENT**
I/we voluntarily consent to medical treatment and diagnostic procedures provided by Medical Group of the Carolinas and its associated hospitals, physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

**AUTHORIZATION FOR RELEASE OF INFORMATION**
The hospital, practice and attending physician are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment. To include information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

**UNDER ASSIGNMENT OF INSURANCE BENEFITS**
I/we hereby grant permission and consent to the District, our assignees, and third party collection agents: (1) to contact me by telephone at any telephone number associated with me, including wireless numbers: (2) to leave answering machine and voicemail messages for me, and include in any such messages information required by law (including debt collection laws) and/or regarding amounts owed by me: (3) to send me text messages or emails using any email addresses I provide: (4) to use pre-recorded/artificial voice messages and/or an automatic dialing device (an "auto dialer") in connection with any communications made to me or related to my account.

**ASSIGNMENT OF INSURANCE BENEFITS**
I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and the District. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand the District can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected following the SC Setoff Debt Collection Act, I/we shall pay all collections fees and costs, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

**WORKER'S COMPENSATION PATIENT RECORDS RELEASE AND AUTHORIZATION FORM**
I/we understand that South Carolina and North Carolina Worker's Compensation law provides that written information which pertains directly to a workers' compensation claim must be provided by a healthcare facility/physician to the insurance carrier, the employer, the employee, their attorneys, or the applicable State Workers' Compensation Commission pursuant to the SC Code Ann § 42-15-95 and NC ST § 97-27. **I authorize Spartanburg Regional Healthcare System (SRHS) to provide copies of my medical records or to speak to duly authorized representatives of any of the above regarding my medical records, medical treatment, or condition.**

**PHOTO/VIDEO/TELEVISING**
I/we consent to photographs, televising and/or videotaping for identification, diagnosis and/or treatment purposes. I/we consent to video monitoring in patient care areas for clinical care and safety reasons.

**INDEPENDENT STATUS OF PHYSICIANS**
I/we understand and agree that some of the practitioners furnishing services to me/the patient, such as radiologists, pathologists and anesthesiologists may be independent contractors and not employees or agents of the Hospital. These independent contracted practitioners, not the Hospital, are responsible for their own acts or omissions. These independent contracted practitioners who render professional services to me/the patient may bill and collect separately from the Hospital. Futhermore, I/we understand that each healthcare provider may be individually contracted with an HMO or PPO. The contracts could be different from the contracts the Hospital holds. I/we understand that I/we need to find out if each healthcare provider is a member of my/the patient's insurance provider network.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**
I/we have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. The Notice of Privacy Practices may be accessed at www.srhs.com.

| | |
|---|---|
| _____<br>Patient Date of Birth | ----------<br>Patient Name |
| _____<br>Date and Time | ----------<br>Signature of Patient/(Relationship to Patient<br>Parent, Guardian or Legally Authorized Representatives |
| ----------<br>Hospital Witness | _____<br>Signature of Guarantor (Relationship to Patient) |

Physical Activity Readiness Questionnaire - PAR-Q (revised 2002)

# PAR-Q & YOU

## (A Questionnaire for People Aged 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

| YES | NO | | |
|---|---|---|---|
| ☐ | ☐ | 1. | **Has your doctor ever said that you have a heart condition <u>and</u> that you should only do physical activity recommended by a doctor?** |
| ☐ | ☐ | 2. | **Do you feel pain in your chest when you do physical activity?** |
| ☐ | ☐ | 3. | **In the past month, have you had chest pain when you were not doing physical activity?** |
| ☐ | ☐ | 4. | **Do you lose your balance because of dizziness or do you ever lose consciousness?** |
| ☐ | ☐ | 5. | **Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?** |
| ☐ | ☐ | 6. | **Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?** |
| ☐ | ☐ | 7. | **Do you know of <u>any other reason</u> why you should not do physical activity?** |

## If you answered

### YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want — as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

### NO to all questions

If you answered NO honestly to <u>all</u> PAR-Q questions, you can be reasonably sure that you can:

- start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

**DELAY BECOMING MUCH MORE ACTIVE:**

- if you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- if you are or may be pregnant – talk to your doctor before you start becoming more active.

**PLEASE NOTE:** If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

<u>Informed Use of the PAR-Q</u>: The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.



NOTE: If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

NAME _____

SIGNATURE _____ DATE _____

SIGNATURE OF PARENT or GUARDIAN (for participants under the age of majority) _____ WITNESS _____

**Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.**

Spartanburg Regional Healthcare System

Corporate Health

# SUBMAXIMAL BICYCLE TEST

Name: _____Employer: _____

SSN: _____ Position: _____

Age: _____ DOB: _____WT:_____ HT:_____ Sex: ☐ M ☐ F

Participant has completed:
_____Fitness Readiness Screening _____ Informed Consent _____ PAR questionnaire

**PRE-TEST INFO**

220-_____=_____ X 0.85=_____(HR Upper Limit) Resting B/P:_____
(age) max HR X 0.75=_____ (HR Lower Limit) Resting Pulse:_____

**PHYSICAL FINDINGS**

☐ Alert
☐ Activity Level: ☐ Inactive ☐ Active ☐ Very Active
☐ Smoke ☐ Dip ☐ Chew

Have you recently experienced any illness or symptoms that would make physical activity challenging?
☐ Yes ☐ No If yes, provider should be made aware before beginning the bicycle test.

**Warm up 2-4 min. b/t 50-60 rpm**

| STAGE WORKLOAD | B/P | HR | RPE |
|---|---|---|---|
| 1 50 watts | _____ | _____(5min) | _____ |
| 2_____ | _____ | _____(9min) | _____ |
| 3_____ | _____ | _____(13min) | _____ |
| 4_____ | _____ | _____(17min) | _____ |
| 5_____ | _____ | _____(22min) | _____ |

| HOLD | B/P | HR | RPE |
|---|---|---|---|
| 85% max | _____ | _____(2 min) | _____ |

| RECOVERY: | B/P | HR |
|---|---|---|
| 1ST minute | _____ | _____ |
| 2ND minute | _____ | _____ |
| 3RD minute | _____ | _____ |

**HEMODYNAMICS DURING TEST (optional)**

☐ Tolerated test well
☐ Asymptomatic
☐ Symptomatic
☐ chest pain ☐ shortness of breath ☐ nausea ☐ hypotension ☐ hypertension ☐ other
Other comments _____

**POST TEST INFO**

Physical findings:
☐ Returns to baseline quickly
☐ Recovers well
☐ Other:

Exercise BP Max:_____
Exercise HR Max:_____
Max Workload:_____

_____ _____
Evaluator Signature Date

Spartanburg Regional Healthcare System

Corporate Health

**Exercise Test Questionnaire and Informed Consent**

**Name:_____ Soc.Sec #:_____**

**Please circle the correct answer.**

1. Has your physician ever told you:
   - That you have heart trouble? yes no
   - That your blood pressure is too high? yes no
   - That you have a bone or joint problem that would be aggravated by exercise? yes no
2. Do you ever feel faint or dizzy? yes no
3. Do you ever have chest pains? yes no
4. Is there a good reason why you should not follow an exercise program? yes no

You will perform a sub-maximal exercise test on a bicycle. The exercise intensity will begin at a low level and be advanced in stages depending on your fitness level. The test may be stopped at any time due to signs of fatigue, changes in heart rate or blood pressure. You may stop the test at any time you wish because of feelings of fatigue or discomfort.

You may experience certain changes during this test. They may include abnormal blood pressure, fainting, irregular, fast or slow heartbeat, and in rare instances, heart attack, stroke and death. Every effort will be made to minimize these risks by evaluation of preliminary information and by observation during the test. Emergency equipment and trained personnel are available to deal with unusual situations that may arise.

Information about your health status or previous experiences of unusual feelings with physical effort may affect the safety and value of the exercise test. It is very important that you report your feelings during the test to the staff. You are responsible for fully disclosing such information to the staff.

The results obtained from this test may assist in the diagnosis of an illness.

Your permission to perform this exercise test is voluntary. You are free to stop the test at any point. Please ask the staff any questions that you may have about the test or its results.

**I have read this form, and understand the test procedures, the risks and benefits, and discomforts that may occur. I have been given the opportunity to ask questions. I consent to participate in this test.**

_____

**Participant Signature** **Date**

_____

**Witness Signature** **Date**

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Fax: 864-801-4398


*Thank you for choosing Spartanburg Regional for your organization's healthcare needs*

**PATIENT INFORMATION** **Please print or write legibly**

Date: _____

First Name_____ Middle Initial_____ Last Name_____

Date of Birth: _____ Sex: M F _____ Marital Status: S M LS D W

Social Security#: _____/_____/_____ Email address: _____

**Mailing** Address: _____

City: _____ State_____ Zip_____

Phone: Home:_____ Cell:_____ Work:_____

Preferred Phone: home cell work (circle one)

Street Address (if different from mailing) _____

City: _____State_____ Zip_____

Primary Language_____

**Race**: [ ] White/Caucasian [ ] Black/African American [ ] Native Hawaiian [ ] AM Indian/Alaska Nat
[ ] Asian/E Indian [ ] Unavailable/Unknown

**Ethnicity**: [ ] Hispanic/Latino [ ] Not Hispanic/Latino [ ] Declined