Open Roads

Office Use Only

Physician's Assessment / Consultation Form

Complete as directed and return to:
Open Roads Academy, Inc.
1223 Wilshire Blvd. #351
Santa Monica, California 90403

Student Name _____ **Course Start Date** _____

To the Physician, Licensed Nurse Practitioner, or Physician's Assistant

You are being asked to consult on this Open Roads applicant's medical screening because we want the applicant to have a safe and healthy experience. These courses contain elements of significant physical stress requiring more strength and endurance than most individuals ordinarily encounter.

We have found that people who are in overall good health with average physical ability can successfully complete the program. However, because the programs often take the participants to remote areas where access to medical facilities may be delayed for 8 hours or longer, prevention of serious health hazards becomes paramount.

We appreciate your help, especially in the areas we have targeted as our concern. Your assessment of your patient and our knowledge of the program elements will allow us to make an accurate medical screening decision. Thank you!

PART I Vital Signs/Statistics

Patient's Name _____ Blood Pressure _____/_____

Height _____ Weight _____ **IF applicable, please indicate by how many lbs. patient is over or underweight:** **IF BP is over 150/90, please repeat:**

Second Reading _____/_____

Overweight by _____ lbs. Underweight by _____ lbs. Date Taken _____

Pulse Irregularities □ No □ Yes

IF yes, please describe symptoms and indicate clinical significance:

_____

PART II Physician's Examination

✔ if normal	Describe if abnormal		✔ if normal	Describe if abnormal	
Eyes			Hernia		
Ears			Genitals		
Nose			Back		
Throat / Mouth			CNS		
Neck			Lymph Nodes		
Thyroid			Skin		
Thorax / Lungs			Scars		
Heart			Extremities		
Heart Murmur			Shoulders		
			Knees		
Peripheral Vsls.			Feet		

Abdomen			Other		

PART III Specific Concern

This patient will be attending a 4-week summer Program in the Pacific Northwest. While the program is open to students of any physical ability, we will be engaging in some or all of the following activities

Specific concern:	
	Backpacking with 40-50 lb. pack, hours at a time, over rough terrain
	Remote wilderness setting—potentially several hours (8-plus) from emergency medical facility
	Sea-Kayaking up to 6 hours per day for up to 4 day in a row
	White Water rafting up to 6 hours per day for up to 4 days in a row
	Activities may take place at elevations up to 10,000 feet above sea level
	Other:
Based on your knowledge of this patient, do you recommend any restrictions to the above activities (indicated by X)?	

PART IV Cardiovascular Testing

This program will include lots of physical activity. Cardiovascular response may produce an unusually high pulse rate. If this patient has a sedentary lifestyle, is significantly overweight, and/or has any of the following cardiovascular risk factors, we may suggest (in some cases, require) further cardiovascular testing be done prior to participation in the program.

Risk Factors:

Diagnosed high blood pressure, even if being controlled with medication
Smoker
Diabetic requiring medication
Known abnormally high cholesterol level or on a diet or medication for a lipid abnormality
Family history (parent/sibling) heart attack, coronary artery by-pass/angioplasty, or sudden, unexplained death before age 55
Current cardiovascular disease
History of prior heart disease
Unexplained chest pain/pressure, shortness of breath, heart palpitations, sweats or exertional dizziness/faint spells

1. Has this patient had an Exercise Test within the past year? ☐ **No** ☐ **Yes** **If yes, results:** _____

2. Do you think an Exercise Test is needed? ☐ **No** ☐ **Yes** **If yes, date scheduled:** _____/_____/_____

3. Results: ☐ **Normal** ☐ **Abnormal** **Participation in this program will depend upon interpretation of the test.**

4. Please forward a copy of the test summary**:** ☐ **Enclosed** ☐ **Will FAX** **FAX #** (School Fax #)

PART V Physician Signature ALWAYS REQUIRED

Physician Signature _____ Date of Exam _____/_____/_____

Telephone # (_____)_____ FAX # (_____)_____ email Address _____