

**Mid-Ohio Psychological Services, Inc.  
Physical Health Assessment Review Feedback**

Location:  Columbus  Delaware  Lancaster  Newark  Ross

Client Name: \_\_\_\_\_ ID: \_\_\_\_\_  
Clinician: \_\_\_\_\_ Review Date: \_\_\_\_\_

**Please do the following:**

- Have client SIGN the Physical Health Assessment.**
  
- Have client COMPLETE the Physical Health Assessment.**
  
- Verify immunizations.**
  
- Instruct client to contact their physician for the following reason (and note in case note):**
  
- Other:**

**Please note the following:**

- Mental health condition may be affected by the following medical condition:**
  
- Mental health condition may be affected by the following medication:**
  
- Other**  **Return to agency nurse.**
  
- Return to file room.**

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**Staff Registered Nurse**