Parish Nursing Services
Screening Form

Date:_____
Site:_____

Name	Age	Results	Under MD care?	Comments	Initials
			Y N		
			Y N		
			Y N		
			Y N		
			Y N		
			Y N		
			Y N		
			Y N		
			Y N		
			Y N		
			Y N		
			Y N		
			Y N		
			Y N		
			Y N		
			Y N		
			Y N		
			Y N		

Parish Nurse X_____ Signature/Initial _____

Congregation _____ Signature/Initial _____

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