SUMMIT COUNTY PUBLIC HEALTH REGISTRATION FORM

www.scphoh.org

1867 West Market Street ♦ Akron, Ohio 44313-6901

Phone: (330) 923-4891 ♦ Toll-free: 1 (877) 687-0002 ♦ Fax: 330-752-7925

Today's Date: ____________________________

Reason for Visit:

☐Received a post card ☐Received a phone call ☐New patient ☐Return visit

How did you hear about us:

____

____

Patient Information:

Last Name:______________________________ First Name: ____________________________Middle Initial: _______

Address: ________________________________ City: ______________________ State: ___________ Zip: _________

Home Phone: ____________________ Cell Phone: ___________________ E-Mail Address: ______________________________

Date of Birth: ____/____/______ Age:______ Male ☐ Female ☐ Social Security Number:_____________________

Single ☐ Married ☐ Divorced ☐Separated ☐ Widowed ☐ Minor ☐

Mark all that apply: African American ☐ Caucasian ☐ Asian ☐ Hispanic ☐

American Indian-Alaskan Native ☐ Other__________________☐

In Case of Emergency, who should be notified? ____

Phone: ( ) ____________________________________ Relationship: ___________________________________

Doctor's Name: ____ Phone number: _________________________

Specialty Doctor's Name: _________________________________ Phone number: _________________________

Dentist's Name: _______________________________________ Phone number: _________________________

Insurance information

☐I have insurance coverage Does your insurance cover immunizations? ☐Yes ☐No

☐I have no insurance coverage Would you like a Medicaid application ☐Yes ☐ No

Primary Insurance Coverage

Name and Address of insurance company ____ Effective date____/____/______

Name of person on card ____________________________________ SS #________________ Birth date____/____/_____

ID # on card ___________________________________ Group # on card ______________________________________

Secondary Insurance Coverage

Name and Address of insurance company ____ Effective date____/____/______

Name of person on card ____________________________________ SS #________________ Birth date____/____/____

ID # on card ___________________________________ Group # on card ______________________________________

☐ Please check this box if you would like information about other resources or programs offered in our community. (If you have specific needs for your family, you may list them below and a nurse will be happy to help you when you are seen)

Thank you for visiting our clinic!

- -

I acknowledge that I have been offered a copy of the Notice of Privacy Practices

____

Client or Guardian Signature **Date**

TB HISTORY FORM

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DEMOGRAPHICS

Last name First Name MI D.O.B. M / F Age

Address City County State Zip Code

Telephone _____/_____/_____ Client signature_____
Home Work Cell

Date _____

SKIN TEST INFORMATION

Reason for this test? School _____ Work _____ Symptoms _____ Other _____

Past TB Skin Test: Yes ____ No ____ If yes, date of test _____ Results _____

Have you received a live vaccine in the last 42 days? Yes_____ No_____

Previous Chest X-Ray? Yes ____ No ____ If yes, date of x-ray _____ Where x-ray done _____

Have you ever been exposed to someone with active TB? Yes ____ No____ If yes, When? _____

To whom were you exposed? _____

Mantoux #1 Date/time placed _____ Site _____ Man/ Lot # _____ Nurse signature _____

Date/time read _____ Result: _____ Size _____mm* Nurse signature _____

Mantoux #2 Date/time placed _____ Site _____ Man/ Lot # _____ Nurse signature _____

Date/time read _____ Result: _____ Size _____mm* Nurse signature _____

QUANTIFURON DONE:_____

Criteria for Classifying Positive TST Reactions

Reaction of ≥ 5 mm of induration is considered positive in	**Reaction of ≥ 10 mm of induration is considered positive in**	**Reaction of ≥ 15 mm of induration is considered positive in**
• HIV-infected persons • Recent contacts of infectious TB cases • Persons with fibrotic changes on chest radiograph consistent with prior TB • Organ transplant recipients • Persons who are immunosuppressed for other reasons (e.g., taking the equivalent of > 15 mg/day of prednisone for 1 month or more, taking TNF-a antagonist	• Recent immigrants (within last 5 years) from a high-prevalence countries) • Injection drug users • Residents of employees of high risk congregate settings • Mycobacteriology laboratory personnel • Children< 4 years of age, or children or adolescents exposed to adults at high risk • Persons with clinical conditions previously mentioned	• Persons with no known risk factors for TB* *Although skin testing programs should be conducted only among high risk groups, certain individuals may require TST for employment or school attendance. An approach independent of risk assessment is not recommended by CDC or the American Thoracic Society.

If TST is 5 mm or greater, complete sections A and B

Section A: Symptom Review

Date of Interview: _____ Nurse Conducting Interview _____

Check appropriate answer

	Yes	No	Comments
Fever			
Chills			
Night Sweats			
Cough			If yes, how long has cough occurred: Is there sputum production: Is there hemoptysis:
Shortness of Breath			
Loss of appetite			
Unexplained weight loss			If yes, number of pounds in number of weeks:
Chest pain			
Smoker			

Section B Risk Factors

Check appropriate answer

	Yes	No	Comments
Contact to active TB case?			
Foreign born			
HIV positive			
Injectable drug use			
Organ transplant			
Homeless			
Diabetes			
Prolonged steroid or immunosuppressive drug use			
Silicosis			
Works in high risk facility			
Lives in high risk facility			
Chest or abdominal surgeries			

Based on symptoms, does patient need to be evaluated for acute TB infections? Yes ____ No ____

Based on risk factors, does patient meet criteria for a positive TST? Yes ____ No ____

Disposition

_____ No referral needed; does not meet criteria for positive test

_____ Refer to private physician for evaluation of TB/LTBI
Private physician name: _____

_____ Local health department for evaluation of TB/LTBI
Chest x-ray ordered: Yes ____ No ____
Physician evaluation: Yes ____ No ____

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PATIENT CONTACT DIRECTIVES

Last Name: _____First Name: _____Middle Initial: _____

Date of Birth: _____/_____/_____ Phone Number (Home/Cell)_____ Language:_____

Patient Privacy Directives
In our efforts to comply with the health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Do we have permission to:
Contact you on the number listed above to discuss appointments, treatment or test results?
☐Yes ☐No

Leave a message regarding appointments on the number listed above?
☐Yes ☐No

Would you like us to text health information to you? (Encoded STD test results only)
☐Yes ☐No

*Would you like us to share health or payment information with close friends or relatives, directly involved with your care?
☐Yes ☐No

If yes:

*Please provide us with a name and phone number that we may leave messages regarding **appointments**:
Name:_____Number:_____(Home/Cell//Email)

Relationship to Patient _____

*Please provide us with a name and phone number that we may leave a message regarding **treatments and/or test results.**
Name:_____Number:_____(Home/Cell/Email)

Relationship to Patient_____

*Do you have any other specific instructions/requests about how we should communicate with you or others about your appointments, treatment, or test results?_____
_____

I acknowledge that all information above is accurate. You must inform us **in writing** of any changes in your directives.

_____ _____ ____/____/_____
Signature Printed Name Date

PATIENT:_____

DATE OF BIRTH:_____

VITAL SIGNS: REFERRED TO PCP_____
WT: _____TEMP:_____BP:_____/_____
PULSE:_____RESPIRATIONS:_____

Screening Checklist for Contraindications to Vaccines for Adults

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

		Yes	No	Don't Know
1.	Are you sick today?	☐	☐	☐
2.	Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3.	Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4.	Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder.	☐	☐	☐
5.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6.	In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs: drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis: or have you had radiation treatments?	☐	☐	☐
7.	Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
8.	During the past year, have you received a transfusion of blood of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9.	For women: Are you pregnant or is there a chance you could become Pregnant during the next month?	☐	☐	☐
10.	Have you received vaccinations in the past 4 weeks?	☐	☐	☐

11. List all of the prescriptions and over the counter medications you are taking and why:

_____ _____ _____

_____ _____ _____

Form completed by:_____ Date:_____

Form reviewed by: _____ Date:_____

Did you bring your immunization record with you? ☐ Yes ☐ No

Technical content reviewed by the Centers for Disease Control and Prevention www.immunize.org/catg.d/p4065.pdf • Item#P4065 (10/12)

Immunization Action Coalition • 1573 Selby Ave. • St. Paul, MN 55104 • (651) 647-9009 • www.immunize.org • www.vaccineinformation.org

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Relationship to Patient _____

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_____ _____ ____/____/_____
Signature Printed Name Date